STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

IN RE: New England Home Care, Inc.
57 Plains Road
Milford, CT 06460

CONSENT ORDER

WHEREAS, New England Home Care, Inc. of Milford, CT ("Licensee"), has been issued License No. C841203 to operate a Home Health Care Agency under Connecticut General Statutes 19a-490 by the Department of Public Health (the "Department"); and

WHEREAS, the Facility Licensing & Investigations Section ("FLIS") of the Department conducted unannounced inspections on various dates commencing on March 1, 2004 up to and including August 23, 2005 for the purpose of conducting multiple investigations and licensing and certification inspections; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of Connecticut General Statutes and/or Regulations of Connecticut State Agencies in violation letters dated October 12, 2004 (Exhibit A – copy attached), December 2, 2004 (Exhibit B – copy attached) and August 26, 2005 (Exhibit C – copy attached); and

WHEREAS, informal conferences with respect to the violation letters were held on October 26, 2004, March 9, 2005 and September 9, 2005; and

WHEREAS, the foregoing acts constitute grounds for disciplinary action pursuant to section 19a-494 of the General Statutes of Connecticut, taken in conjunction with Sections 19a-13-D66 et seq. of the Regulations; and,

WHEREAS, the parties desire to fully resolve the matter without further proceeding; and,

WHEREAS, the Licensee, in consideration of this Consent Order, without admitting any wrongdoing, has chosen not to contest the above allegations before a hearing officer and further agrees that this Consent Order shall have the same effect as if proven and ordered after a full hearing pursuant to section 19a-494 of the General Statutes of Connecticut; and,

NOW THEREFORE, the Facility Licensing & Investigations Section of the Department of Public Health of the State of Connecticut acting herein and through Marianne Horn, its Section Chief, and the Licensee, acting herein through Kimberly Nystrom, its President, hereby stipulate and agree as follows:

1. The Licensee understands and agrees this Consent Order, and the violations contained therein, will be deemed admissible as evidence in Department proceedings and will not be contested in any subsequent proceeding before the Department in which (1) the Licensee's compliance with this same Consent Order is at issue, or (2) the Licensee's compliance with any state or federal statute and/or any state, federal, or departmental regulation is at issue in such proceeding before the Department.

2. The Licensee understands that this Consent Order fully and completely resolves the allegations referenced above without any further proceeding before the Department.

3. The Licensee waives the right to a hearing on the merits of this matter.

4. The Licensee understands this Consent Order is a matter of public record.

5. The Licensee within seven (7) days of the execution of this Consent Order shall designate an individual within the Facility who has responsibility for the implementation of this Consent Order. The assigned individual shall be responsible for maintaining the reports described in this Consent Order and for making such reports available to the Department upon request, and shall provide the Department with a monthly status report regarding the Licensee's efforts to comply with the terms of this Consent Order.

6. Effective upon execution of this Consent Order, the Licensee through its Governing Body, Administrator, Branch Directors and Supervisors of Clinical Services shall take reasonable steps to ensure that:
    a. All patients are initially assessed in a timely and comprehensive manner and all subsequent re-assessments are comprehensive and completed as often as necessary depending on the condition of the patient;
    b. All patients shall have a comprehensive plan of care developed and/or revised which is based on the individual patient's assessment and is reflective of the needs of the patient; prompt action shall be taken regarding any patient's deteriorating health and/or safety status;
    c. Each patient's personal physician or covering physician is notified in a timely manner of any significant change in condition;
    d. All services provided to patients will be coordinated to support the goals and objectives outlined in the plan of care and in accordance with the written plan of care; all care provided to patients by licensed practical nurses is coordinated by and under the direction and supervision of a registered nurse;
    e. All care and services furnished to patients shall be provided by appropriately credentialed staff members who have been determined to be competent to provide the services and whose clinical competency is monitored and evaluated on an ongoing basis;
    f. For all patients for whom goals have not been met and for whom a premature discharge is being considered, the agency will conduct a case review, as

described in section 19-13-D72 (a)(3)(D) of the Regulations of Connecticut State Agencies with all appropriate parties, prior to any decision and/or action to discharge the patient;

7. The Licensee shall ensure that Clinical records shall be kept secure at all times.

8. The Licensee shall maintain documentation regarding compliance and monitoring of a. through g. for a period of two (2) years. Said information shall be available to the Department upon request.

9. The Licensee shall execute a contract with an Independent Nurse Consultant (INC) approved by the Department within two (2) weeks of the effective date of this Consent Order. The INC's duties shall be performed by a single individual unless otherwise approved by the Department.

10. The INC shall function in accordance with FLIS's INC Guidelines (Exhibit D – copy attached). The INC shall be a registered nurse who holds a current and unrestricted license in Connecticut. The Registered Nurse assuming the functions of the INC shall not be included in meeting the staffing requirements of the Regulations of Connecticut State Agencies.

11. The INC shall provide consulting services for a minimum of six (6) months at the Facility unless the Department identifies through inspections that a longer time period is necessary to ensure substantial compliance with applicable federal and state statutes and regulations. The INC shall be at the Facility thirty-two (32) hours per week and shall arrange his/her schedule in order to be present at the Facility at various times on all shifts including holidays and weekends. The Department may, in its discretion, at any time, reduce or increase the hours of the INC and/or responsibilities, if the Department determined the reduction is warranted. The terms of the contract executed with the INC shall include all pertinent provisions contained in this Consent Order.

12. The INC shall have a fiduciary responsibility to the Department.

13. The INC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within two (2) weeks after the contract is approved by the Department. The INC shall confer with the Licensee's Administrator, Supervisors of Clinical Services and other staff determined by the INC to be necessary to the assessment of nursing services and the Licensee's compliance with federal and state statutes and regulations. The INC shall make recommendations to the Licensee's Administrator and Supervisors of Clinical Services for improvement in the delivery of direct patient care by the Facility. If the INC and the Licensee are unable to reach and agreement regarding the INC's recommendation(s), the Department, after meeting with the Licensee and the INC shall make a final determination, which shall be binding on the Licensee.

14. The INC shall submit weekly written reports to the Department documenting:
    a. the INC's assessment of the care and services provided to patients;
    b. the Licensee's progress toward substantial compliance with applicable federal and state statutes and regulations;
    c. any substantial recommendations made by the INC and the Licensee's response to implementation of the recommendations.

15. Copies of all weekly INC reports shall be simultaneously provided to the Governing Authority, Administrator, Branch Directors and Supervisors of Clinical Services.

16. The INC shall have responsibility for:
    a. Assessing, monitoring and evaluating the delivery of direct patient care with particular emphasis and focus on the delivery of nursing services by registered nurses, licensed practical nurses and home health aides and for implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained for a period of two (2) years by the Licensee for review by the Department;
    b. Assessing, monitoring and evaluating the coordination of patient care and services delivered by the various health care professionals providing services and/or others involved in the plan of care;
    c. Recommending to the Department an increase in the INC's contract hours if the INC is unable to fulfill the responsibilities within the stipulated hours per week; and
    d. Monitoring the implementation of the Licensee's plan of correction submitted in response to the violation letters dated October 12, 2004, December 2, 2004 and August 25, 2005 (Exhibits A, B, C).

17. The INC, the Licensee's Administrator and Branch Directors shall meet with the Department every six (6) weeks after the effective date of this Consent Order and throughout the tenure of the INC. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

18. Any records maintained in accordance with any state or federal statute or regulation or as required by this Consent Order shall be made available to the INC and the Department, upon request.

19. The Department shall retain the authority to extend the period the INC functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state statutes and regulations. Examples of violations that may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in condition, failure to provide care and treatment to patients identified with unstable health conditions; failure to implement physician orders or plans of care; or failure to coordinate care appropriately with all disciplines and/or persons and/or entities involved in the

patient's plan of care. Determination of substantial compliance with federal and state statutes and regulations will be based upon findings generated as the result of onsite inspections conducted by the Department.

20. The Licensee shall immediately notify the Department if the position(s) of Administrator, Branch Directors, Supervisor(s) of Clinical Services become vacant due to resignations. In the event of a vacancy in any of these identified positions, the Administrator shall provide the Department with weekly reports pertaining to recruitment efforts until the position is refilled.

21. The Licensee shall, within sixty (60) days of the effective date of this Consent Order, review and revise, as necessary, each patient's plan of care based upon the patient's current and ongoing assessments. Said care plan shall identify each individual patient's problems, needs and goals in accordance with federal and state statutes and regulations.

22. The Licensee shall, within twenty one (21) days of the effective date of this Consent Order, review and revise, as necessary, all policies and procedures which are pertinent to: patient assessment; development, implementation and revision of the plan of care; medication administration and management; coordination of services; clinical protocols including, but not limited to, the management of wound care, diabetes and patients with psychosocial/mental health needs including patients with co-morbid conditions; initiation and delivery of social work services; patient discharge, including premature discharge; notification of the physician of the condition of the patient including concerns for the patient's safety, and the credentialing and monitoring of staff competence.

23. The Licensee shall confirm within thirty (30) days of the effective date of this Consent Order that all direct service staff have been in-serviced on topics relevant to the provisions of paragraphs 6, 21 and 22 of this document. If such in-service had not been provided in November 2004 or if the staff member failed to attend the November 2004 in-service education programs, the Licensee will in-service all such direct service staff within thirty (30) days of the effective date of this Consent Order. If the results of the review outlined in paragraph 21 identifies deficient practices in need of further in-service education, such additional in-service as necessary to address such identified deficient practices shall be conducted within sixty (60) days of the effective date of this Consent Order. The Licensee shall maintain an attendance roster of all in-service presentations that shall be available to the Department for a period of two (2) years.

24. In accordance with the following schedule for each Patient Service Office, which commences upon execution of this Consent Order, the Licensee shall audit the medical record of each patient currently receiving services to ensure that each patient's current condition is accurately and consistently documented and that care is provided in accordance with the plan of care. The completion schedule is as follows:
    a. Milford Patient Service Office completed within thirty-one (31) weeks of the

effective date of this Consent Order;

b. Cromwell Patient Service Office completed within thirty-three (33) weeks of the effective date of this Consent Order;
c. Waterbury Patient Service Office completed within fifteen (15) weeks of the effective date of this Consent Order;
d. West Hartford Patient Service Office completed within twenty-two (22) weeks of the effective date of this Consent Order.

25. Within ten (10) days after the completion date specified above for the medical record audits, all direct care staff in the applicable Patient Service Office shall be provided with necessary in-service education to address any deficient practices identified as a result of the medical record audits described in paragraph 24. Documentation of such in-services shall be maintained by the Licensee for review by the Department for a period of two (2) years.

26. The Licensee shall, within thirty (30) days of the effective date of this Consent Order build in to the agency's current quality assurance program, an additional quarterly clinical record audit program. Said program is to consist of a random review of one hundred (100) clinical records of the current caseload maintained by the Licensee. Such review is to be conducted by a different clinical supervisor than the clinical supervisor assigned to the case in order to ensure that agency policies are being followed and that the provisions relevant to paragraphs 6, 21 and 22 are in compliance. A summary report of the results of the above audit program shall be submitted to the Branch Directors and agency administrator within thirty (30) days of completion of the audits, for review, evaluation and implementation of interventions to remedy any identified deficient practices. The administrator shall prepare a report of program's progress toward goals to be presented to the Professional Advisory Committee at its next scheduled meeting. Said reports shall be available for review by the Department for a period of two (2) years.

27. The Licensee shall, within thirty (30) days of the effective date of this Consent Order build in to the agency's current program to evaluate the clinical competency of all professional direct service staff that, as a minimum, the Supervisor of Clinical Services or clinical designee and/or Unit Directors of Specialty Services will conduct joint home visits with each primary care nurse ("PCN") to assess clinical competence and to initiate a program of remediation, if appropriate. Joint home visits will be scheduled at least quarterly for those PCNs who work 25-40 hours per week or average 25 or more visits weekly on a per diem basis. Two joint visits will be conducted by a qualified Supervisor of Clinical Services and two visits by a clinical designee with at least 2 years of home care experience. Nurses who work less than full time or average less than 25 visits weekly on a per diem basis will have two joint visits per year, one of which will be conducted by the Supervisor of Clinical Services and one by a clinical designee with at least 2 years of home care experience. Nurses who work 3 visits or fewer per week shall have one clinical field supervision per year as per state regulations conducted by the Supervisor of Clinical Services or by a clinical designee with at least 2 years of home care experience. At least annually, one

joint home visit will include supervision of the home health aide if applicable. Joint home visits conducted from May 1, 2005 forward shall be counted toward the satisfaction of the requirements set forth in paragraph 15.

28. Upon execution of and for the duration of this Consent Order, New England Home Care shall petition the Department for approval to open any additional patient service office(s) and/or to grant any new Home Health Care Agency license in the State of Connecticut. After the Consent Order has been in effect for the duration of one (1) year, the Department may, in its discretion, decrease the length of time required for approval by the Department to open any additional patient service office(s) and/or to grant any new Home Health Care Agency license in the State of Connecticut.

29. The Licensee upon the execution of this consent order shall pay a financial penalty of eight thousand dollars ($8,000.00). Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Order. The financial penalty shall be in the form of a money order or bank check payable to the Treasurer of the State of Connecticut.

30. The financial penalty and any other reports required by this Consent Order shall be directed to:

Victoria V. Carlson, R.N., M.B.A.
Supervising Nurse Consultant, Department of Public Health,
Facility Licensing & Investigations Section
410 Capitol Avenue, MS #12 HSR
P.O. Box 340308
Hartford, CT 06134-0308

31. The provisions of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document.

32. The execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.

33. The Licensee understands legal notice of any action shall be deemed sufficient if sent to the Licensee's last known address of record reported to the Facility Licensing & Investigations Section.

34. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this document or of any other statutory or regulatory requirements. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Department may petition any court with proper jurisdiction

for enforcement of this Consent Order in the event the Licensee fails to comply with its terms.

35. The Licensee has had the opportunity to consult with an attorney prior to signing this document.

36. The Licensee understands this Consent Order is effective upon approval and acceptance by the Commissioner's representative, at which time it shall become final and an Order of the Commissioner of Public Health.

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IN WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

NEW ENGLAND HOME CARE, INC
~~OF MILFORD, CT.~~

12/8/05
Date

By: Kimberly Nystrom
Kimberly Nystrom, President

State of Connecticut)
County of Middlesex) ss December 8, 2005

Personally appeared the above named Kimberly Nystrom and made oath to the truth of the statements contained herein.

My Commission Expires: August 31 2007 Kamala A. Zemke

Notary Public	[✓]
Justice of the Peace	[ ]
Town Clerk	[ ]
Commissioner of the Superior Court	[ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

12/13/05
Date

By: Jan Sheavett
For ~~Marianne Horn, R.N., J.D.~~, Section Chief
Facility Licensing & Investigations Section

INDEPENDENT CONTRACTOR AGREEMENT

This Independent Contractor Agreement for consulting services is made between New England Home Care, with an office at 57 Plains Road, Milford, CT 06460, hereafter known as "Company," and Mary Ellyn Blake of Wethersfield, hereafter known as "Consultant."

Consultant is in the business of providing certain nursing consulting services, and Company desires to hire Consultant as an independent contractor on the terms and conditions set forth below. For good and valuable consideration, the parties agree as follows:

1. **Duties**: Company engages Consultant for the provision of Nursing Consulting Services ("Consulting Services"), as described on the attached Consent Order and Independent Nurse Consultant Guidelines and for the performance of all professional responsibilities associated with that engagement.

2. **Term**: Consultant shall provide Consulting Services for a minimum of six (6) months at the Company unless the Connecticut Department of Public Health ("DPH") identifies through inspections that a longer time period is necessary. The Consultant shall be at the Company thirty-two (32) hours per week and shall arrange her schedule in order to be present at the Company at various times on all shifts including holidays and weekends. DPH may, in its discretion, at any time, reduce or increase the hours of the Consultant and/or responsibilities, if the DPH determines that such a change is warranted.

3. **Relationship of Parties**: Consultant shall act at all times as an independent contractor and shall have full control of the work and the manner in which it is performed. Consultant is not considered an agent or employee of Company for any purpose. As set forth in paragraph 12 of the attached Consent Order, the Consultant shall have a fiduciary responsibility to the DPH.

4. **Compensation**: Consultant shall work in the offices of Company during normal business days. Consultant shall charge Company at the rate plus any applicable state sales tax. Consultant shall be responsible for withholding all payroll taxes. Consultant shall prepare a time slip weekly and shall have it signed by Company evidencing all hours worked. Consultant shall bill Company on a weekly basis. Out-of-pocket expenses of Consultant will be paid by Company only with prior written authorization of Company.

   As an independent contractor, Consultant understands the he or she is not eligible to receive, and hereby disclaims and waives any right to receive, any employee benefits of Company including but not limited to paid vacations, holiday pay, sick leave, pension and retirement benefits, medical and dental benefits, incentive plans, stock purchase plans or any other benefits offered or which may in the future be offered by Company to its employees. Consultant also understands that, as an independent contractor, he or she is not eligible to receive unemployment compensation benefits from Company. As part of the compensation provided under this agreement, however, the Company shall procure a disability short

term/long term benefits policy for the benefit of the Consultant for the entire terms of this agreement.

5. **Termination**: This Agreement shall terminate on the earlier of the following:

   a. Upon completion of the Term set forth in paragraph 2;

   b. At any time upon written notice by the Consultant to DPH and the Company.

6. **Ownership of Materials**: Upon termination of this Agreement, Consultant shall return to Company any and all materials given to Consultant in connection with the performance of work under this Agreement. In addition, all material created by Consultant as a result of services performed under this Agreement shall be the property of Company (other than the reports that the Consultant is required to provide to the DPH under the terms of the Consent Order), and Consultant agrees to execute any documents necessary to evidence this ownership.

7. **Liability**: Consultant agrees to indemnify and hold harmless Company from any claim of copyright or patent infringement arising out of Consultant's work. Consultant agrees that he or she has a valid license or permission to use any materials brought to Company by Consultant, including but not limited to systems, tools, hardware, software, computer applications, documentation and all other things used or to be used by Consultant.

8. **Protection of Confidential Information**: Consultant understands that, in the course of the engagement, he or she may have access to confidential or proprietary information or trade secrets of Company and/or confidential or proprietary information or trade secrets of third parties working with Company. Consultant agrees that all such confidential and proprietary information and trade secrets shall be kept confidential and shall not be disclosed, except as expressly authorized in writing by Company or pursuant to law. Such information may include, without limitation, protected health information and information relating to current or prospective customers, prices, costs, profits, markets, products, innovations, inventions, non-public financial information, employees and other workers.

9. **General Provisions**: This Agreement supersedes any prior agreements between the parties concerning the subject matter hereof, and can be modified only by written amendment signed by both parties. If any part of this Agreement is held to be unenforceable for any reason, that part shall be severed from the Agreement, leaving valid the remainder of this Agreement. The Agreement will be governed by laws of the State of Connecticut.

COMPANY	CONSULTANT
By: [signature]	By: [signature]
Date: 12/6/05	Date: 12/5/05

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 19

October 12, 2004

William Sullivan, Administrator
New England Home Care
57 Plains Road
Milford, CT 06460

Dear Mr. Sullivan:

Unannounced visits were made to New England Home Care on March 1, 4, 8 and 9, 2004 and August 2, 3, 4, 5, and 6, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting multiple investigations and a licensure inspection with additional information received through September 28, 2004.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for October 26, 2004 at 10 AM in the Division of Health Systems Regulation Conference Room, Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut.

The purpose of the meeting is to discuss the issues identified during the inspection. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, in-service program, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Victoria V. Carlson, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

SNC:NC: A. Komarow
M. Smith

cc: complaint # ; 2003-0453
2003-0376
CT00002317

Phone:
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # _____
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: March 1, 4, 8, 9, 2004 and August 2, 3, 4, 5 and 6, 2004 with additional Information received through September 28, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. The governing authority failed to assume responsibility for the services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 12, 14 and 23 and their families based on the violations listed in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(b)(4)(A) General requirements.

Plan of Correction Completion Date

Provider/Representative Title Date

DATE(S) OF VISIT: March 1, 4, 8, 9, 2004 and August 2, 3, 4, 5 and 6, 2004 with additional Information received through September 28, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

2. The administrator failed to organize and direct the agency's on going functions and to ensure the safety and quality of care rendered to Patient #s 1, 2, 3, 4, 5, 12, 14 and 23 and their families based on the violations listed in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2) General requirements.

Plan of Correction Completion Date

3. The Supervisor of Clinical Services failed to ensure the safety and quality of clinical services rendered to Patient #s 1, 2, 3, 4, 5, 12, 14 and 23 and their families based on the violations listed in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(e)(2)((3)(A)(B)(C) General requirements.

Plan of Correction Completion Date

DATE(S) OF VISIT: March 1, 4, 8, 9, 2004 and August 2, 3, 4, 5 and 6, 2004 with additional Information received through September 28, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

4. Based on clinical record review, home visit observation, patient and staff interviews and agency policy review it was determined that for three (3) of twenty-seven (27) patients the primary care nurse failed to comprehensively re-assess and/or to take prompt action regarding the patient's deteriorating health and safety status; and/or to notify the physician of a change in condition that suggested a need to alter the plan of care and/or to update the plan of care, including interventions to address changes in the patient's condition (Patient #s 4, 12 and 14). The findings include:

a. Patient #4 was admitted to the agency on 1/11/03 with diagnoses including CVA, colon cancer, depression, urine retention and pleural effusion. The physician plan of treatment for the certification period of 1/11/03 to 3/11/03 ordered skilled nursing visits 1-3 x per week; home health aide, 2 hours, 2-4 x per week; physical therapy and social service evaluation; verbal order, dated 1/24/03, ordered increase of skilled nursing visit daily for wound care The plan for skilled nursing was to assess cardio/pulmonary and endocrine status, assess Foley catheter, and assess mental status, functional status/ability for self-care.
i. The nursing comprehensive assessment dated 1/11/03 documented that Patient #4 was totally dependent with bathing, toileting, chair/bedfast, unable to feed self, and totally dependent with all instrumental activities of daily living. The nursing admission assessment dated 1/11/03 documented that Patient #4's skin was within normal limits; skin was intact and no open area. The nursing narrative note dated 1/13/03 documented that Patient #4's buttock was red and duoderm was ordered to the area. The nursing narrative note of 1/16/03 documented that the buttock remained red but skin intact. The nursing narrative note of 1/20/03 documented that the buttock site was opened, 2 x 1 cm, superficial with duoderm applied to area. The nursing narrative note of 1/23/03 documented that the buttock wound was 3 x 4 cm; Physician #1 was notified and agreed to order a wound consult. Documentation was lacking that the family/caregiver received special instruction in providing care to a totally dependent, bed bound patient to prevent skin breakdown. Interview with RN #1 on 4/27/04 at 11:30am identified that, not until the nursing visit of 1/24/03 did she address the live-in care giver and/or document the need to turn and position Patient #4 every two hours.
ii. On 1/24/03 the nursing narrative notes documented that the mid-wound to buttock was stage 3, size 5 x 3 cm, with necrosis, large amount of serous drainage, and a second wound was noted below, size 2-3 cm, stage 3 with necrotic tissue; Physician #1 was notified and he ordered to cleanse wound with normal saline followed by Mesalt dressing. The nursing narrative notes of 1/29, 1/30, 1/31, 2/1, 2/2, and 2/3/03 documented that the wound area remained necrotic with moderate, sero-sanguineous drainage. The nursing narrative note of 2/4/03 documented that

DATE(S) OF VISIT: March 1, 4, 8, 9, 2004 and August 2, 3, 4, 5 and 6, 2004 with additional Information received through September 28, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Physician #1 was notified that the buttock wound site continued to drain sero-sanguineous drainage and the necrosis was 60% of wound. The nursing note dated 2/8/03 documented a large amount of drainage and a foul odor, and Patient #4 complained of difficulty breathing; documentation was lacking that the physician was notified of Patient #4's change in condition due to difficulty breathing, and the deteriorating status of the wounds.

iii. The nursing narrative note of 2/10/03 documented that the two buttock wounds had become one, size 11 x 6 cm, necrotic area remained moderate with sero-sanguineous drainage; live-in caregiver had oral surgery and Patient #4's daughter stayed with the patient; the agency home health aide was to provide 2 hours care per day per week. Documentation was lacking that the physician was notified of the change in Patient #4's wound and/or that Patient #4's daughter received special instructions in the care of a bed bound patient with stage three wounds.

iv. The nursing notes of 2/11/03 documented stage 3 wound to buttock, which continued with necrosis, moderate serosanguinous drainage and redness surrounding the wound; the note also documented that the unlicensed caregiver was instructed in wound care. Nursing notes of 2/12/03 and 2/13/03 noted that the 24-hour live-in caregiver provided wound care on those dates; documentation was lacking of a skilled nursing assessment of Patient #4's wound and/or response to treatment from 2/10/03 until 2/14/04. The nursing note dated 2/14/03 documented that Patient #4's agitation continued, wound had moderate serous drainage and the caregiver was performing wound care; the plan by the primary nurse, RN #1, was to decrease the daily wound care assessments to 2-4 times per week. On interview with RN #1 on 4/17/04 at 11:30am, RN #1 stated that the reason why she decreased the daily skilled nursing visits was because the live-in caregiver (an unlicensed person) was doing the wound care and she felt an assessment 2-4 times per week would be OK. Interview with the Director of Clinical Operations on 9/28/04 stated that RN #1 indicated that she felt it was a duplication of services if she (RN) did the wound care since it was already being completed by the care-giver; and she also indicated that perhaps she (RN) should have completed the wound care and/or undressed the wound to complete the wound assessment.

v. The final nursing narrative note dated 2/17/03 documented that Patient #4 had a temperature of 101.2 degrees, increased agitation, an additional wound with blackened area was found on Patient #4's right leg. The daughter suggested that Patient #4 should be evaluated at the hospital emergency department secondary to inability to go the physician office; daughter called 911 for transfer to Hospital #1. The admission note to Hospital #1, dated 2/17/03, documented that Patient #4 was admitted with increased confusion, weakness, and a question of sepsis; came to the emergency department with generalized weakness and a fever of 99.3 degrees; had multiple decubitus ulcers, which were noted to be infected; had an abnormal urine which suggested urosepsis with increased renal function tests suggesting dehydration; has been living home with

help of various aides and she has been doing poorly; the physical exam noted multiple areas of decubiti, worse on coccyx, and also dressings on her arms.
vi. Review of the agency's wound assessment and documentation policy and procedure noted that the nursing visit report should include the treatment and condition of the wound each visit, appearance of the wound bed (black, yellow, green, tan, red, pink); wound measurements (at least weekly) to include length, depth and width of the wound in centimeters; depth and location of undermining in centimeters; inflammation or erythema of the skin around the wound; color, odor and estimate amount of drainage; stage the wound weekly and compare the progress with the goals of therapy; any patient/caregiver instructions on wound care and compliance with wound management, including ability to change dressings. Review of documentation of Patient #4's skilled nursing visit notes related to wound care assessment identified that wound measurements were lacking from 2/10/03 until the transfer to Hospital #1 on 2/17/03; documentation was also lacking of the wound bed appearance on 1/27, 1/30, 2/2, 2/8, 2/12, 1/13, and 2/14/03.
vii. An interview with the primary nurse (RN#1) was conducted on 4/29/04 to review Patient #4's nutritional status, wound assessments and response to treatment. RN #1 expressed what was reported by the caregiver, i.e. Patient #4 was eating 3 meals per day, which was an improvement to the initial 2 meals she had been eating; the caregiver would prepare soups, mostly soft foods like stews, and eggs in the morning; RN#1 stated that she did instruct the caregiver about proper nutrition such as protein and vitamin C.
viii. The primary care nurse failed to update and revise the comprehensive assessment due to a major decline in Patient #4's sacral decubitus ulcer which progressed from stage 2 to stage 3 within 4 days; and/or to complete a comprehensive nutritional assessment; and/or to take prompt action when the patient's health status deteriorated; and/or to notify the physician of a change in the patient's condition that suggested a need to alter the plan of care; and/or to update the plan of care, including interventions to address changes in the patient's condition; and/or to appropriately delegate all aspects of the care plan, i.e. instructed the care-giver (an unlicensed person) in wound care to a stage 3 decubitus ulcer. See also G173 and G175.

b. Patient #12's start of care date was 7/16/04 with diagnoses including lower extremity ulcer and uncontrolled type I diabetes mellitus. Physician ordered medications included Adalact, Metoprolol, Zestril, Remeron, Lasix, Aspirin, Aranesp, Novilin 70/30 and Novilin N. Documentation on the certification plan of care dated 7/16/04 ordered skilled nurse 1-2x per day x 2 weeks and on 7/30/04 the physician ordered that nursing visits continue twice daily for four weeks more. The nurse was ordered to assess vital signs, general condition, safety and level of function, medication effects and compliance, nutrition, assess blood sugars each visit (taken by

family) and to provide wound care to left lower extremity ulcer measuring 7cm x 5cm x 1cm. Documentation by RN #3 on the certification plan of care dated 7/16/04 stated that the patient required teaching to draw up and to inject insulin.
Clinical record review of the OASIS/comprehensive assessment dated 7/16/04 determined that the 77 year old patient was alert and oriented, lived alone, required assistance with activities of daily living (ADLs) and depended on a temporary 24-hour live-in aide as well as family living outside of the home. RN #3 stated that she instructed the patient and caregivers regarding medications, diet and signs and symptoms to report and she assessed that their knowledge was limited. The patient was able to self inject insulin with the nurse's verbal cues.
Review of the clinical record determined that during the period from 7/16/04 to 8/3/04, the patient's fasting blood sugars consistently ranged from 217 to 595 and beyond, which was measured as "hi" on the patient's glucometer. The nurse often reported the elevated blood sugars to the physician and he ordered to increase insulin at least twice during that period. During the period from 7/16/04 to 8/3/04, agency nurses visited Patient #12 twice daily, but when blood sugars were elevated in the morning, there was no consistent documentation that evening blood sugars were assessed and/or that the patient was assessed for symptoms of hyper/hypoglycemia. When interviewed on 8/10/04 RN #3 stated that no symptoms of hyperglycemia were documented in the clinical record because the patient never exhibited these symptoms. The surveyor observed on 8/3/04, during a joint home visit with the RN, that the patient was irritable and forgetful and the patient told the nurse that when her blood sugar was high she drinks all of the time and has to go to the bathroom a lot. However, there was no clinical record documentation of the patient's symptoms, which were possibly suggestive of hyperglycemia, on the nurse's visit note prepared by RN #3 for the skilled nursing visit of 8/3/04.
There was no clinical record documentation after the admission date to indicate that the nurse continued to teach and/or to assess the patient's and/or her family's ongoing knowledge of diabetes management and/or if the patient adhered to the "no concentrated sweets" diet as ordered by the physician.
When interviewed on 8/10/04 RN #3 stated that she observed that appropriate food was in the home, and she discussed what the patient was eating and dietary restrictions, but failed to document this. RN #3 stated that the patient had a history of erratic blood sugars so she did not check the patient's blood sugar when the patient reported elevated blood sugars, nor did she know if the patient's glucometer had been checked for accuracy.
The registered nurse failed to accurately and appropriately re-evaluate Patient #12's diabetic status when consistently elevated blood sugars suggested that the care plan be altered to possibly include aggressive monitoring of blood sugar levels and symptoms of elevated blood sugar and/or to include more extensive teaching regarding diabetic diet and management.

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i. Clinical record documentation by SCS #1 dated 7/22/04 stated that the patient had fired her live-in aide. Documentation on the OASIS/comprehensive assessment dated 7/16/04 stated that the patient needed help to groom and to bathe and clinical record documentation in the nurses visit notes from 7/16/04 to 7/31/04 consistently stated that the patient's right lower extremity was edematous and she was instructed to elevate the limb as often as possible. On 7/22/04 documentation by SCS #1 stated that the patient refused a home health aide (H-HHA) and that the patient's sisters would assist in her care and prepare meals. During the period from 7/23/04 to 7/29/04 agency nurses continued to visit the patient twice daily, however, there was no clinical record documentation to support that they assessed if this plan was working and/or if H-HHA services, or other alternatives, were needed. Documentation by RN #8 on 7/30, 7/31, and 8/1 on nurse visit notes was as follows:

a). 7/30/04: patient's wound worsening; blood sugar is "all over the place." Encouraged to obtain lifeline for safety, reconsider 24-hour supervision.

b). 7/31/04: Seems very weak, using walker with great effort to walk. Encouraged to get 24-hour live-in care, needs supervision; instructed to obtain cell phone, lifeline for safety. There was no clinical record documentation on 7/30 and/or 7/31 to support that the nurse altered the plan of care to assure the patient's safety and/or that she reported her concerns for the patient's safety to the family and/or to the physician.

c). 8/1/04: Can barely walk, slept all day. Fell downstairs last night (taking garbage out) and scabbed inner forearm. Encouraged sister to obtain lifeline for safety and reconsider 24-hour supervision. RN #8 spoke at length with the patient's sisters about the need for 24-hour supervision because of the safety factors that emerged in the previous two days due to the patient being very weak and having difficulty getting up. RN #8 contacted the physician who stated that the patient's unstable blood sugar was contributing to her weakness and he requested that blood sugars be tested four times a day.

When interviewed on 8/10/04 RN #8 stated that she was always concerned about the patient's safety because she was elderly and lived alone, but the family did not agree; LPN #3 stated that the patient told her that her sisters were at her home daily so she knew the patient was not alone all day. When RN #8 found the patient alone on the evening of 7/31/04 the nurse assessed that the patient was weaker; RN #8 stated that the patient told her that her sisters had been with her earlier, but had left and were not expected to return (on 7/31/04); RN #8 stated that she did not contact the family and/or the physician until after the patient fell on 8/1/04.

ii. Clinical record documentation on a non-visit note by SCS #1 dated 8/2/04 stated that LPN #3 found the patient alone at home (on 8/2/04) and confused with elevated blood sugar. SCS #1 contacted the patient's sister and informed her that the patient was unsafe alone at this time and unless someone could stay with her, the agency would call 911. SCS #1 stated that the patient

did not have a cordless phone and that she could not safely get to the telephone. After speaking with the patient's sister, SCS #1 called LPN #3 at the patient's home and told her to leave a note for the sister to call the agency when she arrived at the home or the on-call nurse would call 911. When interviewed on 8/10/04, LPN # 3 stated that after speaking with SCS #1 she helped the patient to the bathroom and then to the couch where she instructed the patient to stay. LPN #3 stated that she did not assess the patient's orientation by questioning about time, person and place, but that the patient responded appropriately when the nurse spoke to her. LPN # 3 stated that she left the patient alone, but expected that the sister would arrive soon. She estimated that the patient was alone about one half hour according to the on-call nurse's documentation that the sister was there at 5:55 pm when she went to check on the patient. SCS #1 and LPN # 3 failed to accurately and/or appropriately assess the implications of the patient's changed mental status (confusion) that determined she required 24-hour supervision and left the patient alone in an unsafe environment.

iii. During a home visit on 8/3/04 the patient told the surveyor that she needed to hire someone to assist her, but didn't know how she could afford it. The surveyor asked Patient #12 if she was offered a social worker to help her assess her finances and to possibly apply for community home assistance programs. The patient responded that she was never offered a social worker by the home care agency and that she did not know Medicare would help her to have this service. Upon surveyor inquiry the patient stated that she was not aware that a medical social worker (provided by Medicare) could assist her to assess her finances for possible applications for home assistance programs in the community.

When interviewed on 8/3/04 RN #3 told the surveyor that she had not involved social work because she knew that the patient's financial position was above the required income levels that would enable her to apply for community based programs.

RN #3 documented on a nurse visit note dated 8/3/04 that the patient requested a social worker to assist with finances. The nurse failed to appropriately assess the patient's need for social work intervention to thoroughly assess the patient's finances and tc make referrals as appropriate.

b. Patient #14's start of care date was 7/16/04 with diagnoses including post-traumatic wound infection and a left trans-metatarsal amputation The certification plan of care dated 7/16/04 to 9/13/04 ordered skilled nurse daily to assess vital signs, general condition, safety and level of function, complications of wound and wound care with wound vac; also to assess and monitor coping mechanisms, anxiety and emctional status, instruct measures and medications to relieve anxiety. The 10-day summary by RN #6 dated 7/16/04 stated that the patient was 56 years old with recent crushing injury to feet sustaining open fracture to right trans-metatarsal requiring amputation. The wound became infected and incision and drainage was done. He was discharged

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to home with wound vac treatment to an open wound on the left foot that was 6cm x 6.4cm x.8cm. Patient #14 was non-ambulatory with decreased functional ability (he was previously independent in all ADLs). Patient #14 was depressed and weepy and uninterested in his own care needs. On 7/19/04 RN #6 documented on the nurse visit note that the patient and wife were counseled about the importance of working to go forward with plans they had (before the injury). RN #6 stated that the patient was depressed and she encouraged the patient to ask the physician about an antidepressant. During the period from 7/20/04 to 8/4/04 there was no documentation to support that the nurse discussed with the physician the patient's emotional status and/or the possible need for an antidepressant and/or that she re-evaluated the patient's emotional/psychosocial status.

During a joint home visit on 8/4/04 the surveyor made observations of the patient as his dressing was being changed. The patient was noted to be emotionally upset about his situation and he appeared sad and depressed. He told the surveyor that he had lost all of his independence and his dreams for the future and that he felt that he had burdened his family with his needs.

When interviewed on 8/5/04 RN #6 stated that she told the physician her observations on 7/20/04, but that she never asked him to consider anti-depressant medication. She stated that she counsels the patient during each visit and feels he is coping better now than at the start of care. Upon surveyor inquiry RN #6 stated that she never thought to evaluate the patient for medical social services and/or psychiatric nurse interventions to assist with his coping.

When interviewed on 8/5/04 SCS #3 told the surveyor that RN #6 was new to home care. Upon surveyor inquiry regarding mentoring and record review for new professional staff, SCS #3 stated that the agency has been enduring a shortage of staff and it is not possible to review new staff's records, as they would like to.

The registered nurse failed to accurately re-evaluate and/or to document re-evaluation of the depressed emotional status of Patient #14 after he endured traumatic limb loss that caused severe

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losses of function and/or independence that he perceived to be the death of his future dreams and loss of his life goals and/or to discuss with the physician the need for MSW and/or psychiatric nursing interventions and/or interventions regarding his emotional status.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(3)(D) Services.

Plan of Correction Completion Date

5. Based on clinical record review, agency policy review and staff interviews it was determined that for Patient #s 1, 2, and 3 the primary care nurse failed to update the plan of care to reflect changes in the patients' conditions and/or failed to document the coordination of services with all clinicians involved with the plan of care. The findings include:

a. Patient #1 was admitted to the agency on 12/01/00 with diagnoses including schizoaffective disorder, hypertension, esophageal reflux, and cerebrovascular insufficency. The physician's plan of treatment for the certification period of 11/16/03 to 1/14/04 and 1/15/04 to 3/14/04 noted that skilled nursing visits were ordered ten (10) to fourteen (14) times per week for 60 days. The skilled nursing visits were to assess blood pressure and pulse every week, assess disease process,

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assess response and medication compliance, safety, mental/emotional status and signs and symptoms of decompensation; skilled nursing to administer all AM and PM medications per physician orders; provide emotional support. Review of the nursing narrative notes by Assistant Director of Behavior Health dated 2/1/04 documented that Patient #1 went to the emergency department at Hospital #2 on Friday (1/30/04) following an episode of hypotension; no change in the treatment regime, encourage to increase fluid intake, and educate Patient #1 to increase her fluid intake. The nursing notes by LPN #2 on 1/30/04 from 3:30-3:39pm and/or 1/31/04 from 6:38-6:45 am, and/or 2/1/04 from 6:36-6:42 am failed to document an awareness of Patient #1's emergency department evaluation and/or the special instructions from the Assistant Director of Behavior Health on 2/1/04; RN #2's skilled nursing visit on 1/31/04 from 3:35-3:45pm visit also failed to document an awareness of Patient #1's emergency department evaluation for hypotension. Interview with the Assistant Director of Behavior Health on 3/2/04 at 12noon, stated that she provided LPN #2 and RN #2 with special instructions to instruct Patient #1 to increase fluids and to monitor vital signs. Documentation was lacking that the plan of care was updated to reflect these changes and/or evidence of the coordination of all care and services between the RN and LPN was lacking in the patient's clinical record.

i. The nursing narrative notes dated 2/5/04 from 6:16-6:23am by LPN #1 documented that Patient #1 slipped on the back stairs and fell and banged her head on the side wall; patient is alert, no bumps or abrasions noted on head. The evening visit by LPN #2 on 2/5/04 from 4:36-4:42pm failed to document a follow-up related to the fall. Interview with LPN #2 on 3/2/04 at 11:00am identified that she (LPN #2) was unaware of Patient #1's fall; therefore she did not complete a fall follow-up. Interview with Assistant Director of Behavior Health on 3/2/04 noted that she receives a verbal report daily from LPN #1 and LPN #2 but it was not documented.

b. Patient #2's start of care was 10/07/00 with diagnoses including paranoid schizophrenia, diabetes and mental retardation. The physician plan of treatment for the certification period dated 1/19/04 to 3/18/04 ordered skilled nursing visits twelve (12) to fourteen (14) times per week for 60 days. The skilled nursing visits were to assess vital signs weekly, assess disease process, endocrine status, and mental/emotional status; to administer medications every AM and PM. Review of the nursing narrative notes identified Patient #2's blood sugars as follows: 218 on 1/31/04 at 6:31am; 286 on 2/1/04; 189 on 2/2/04; 289 on 2/3/04; 254 on 2/4/04, and 291 on 2/8/04. Interview with LPN #2 on 3/2/04 at 11am identified that she was unaware of the plan for monitoring and reporting blood sugars. LPN #2 stated that she thought the standard was that a blood sugar level of 400 was to be reported; she was unaware of the plan for Patient #2. Interview with Assistant Director of Behavior Health on 3/2/04 identified that Patient #2 was a non-insulin dependent diabetic that always cheated on his diet; the plan following 1/5/04 was to

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increase skilled nursing visits due to non-compliance with self administration of his medications during the previous trial period; the blood sugar was to be reported to the physician at a level of 300. Assistant Director of Behavior Health stated that a blood sugar level of 300 was to be reported to the physician per a verbal order which was not put in writing; Assistant Director of Behavior Health was unaware that LPN #2 was unaware of the plan of care and stated that documentation of the coordination of services around the blood sugar level to report was lacking in Patient #2's clinical record.

c. Patient #3's start of care was 3/3/03 with diagnoses including schizophrenia and hypertension. The physician plan of treatment for the certification period 12/28/03 to 2/25/04 ordered skilled nursing visits nine (9) to eleven (11) times per week for 60 days. Skilled nursing visits were to assess for exacerbation of psychiatric symptoms, disease process, compliance with medication regime, assess mental/emotional status, administer medications 1 time per week and pre-pour medications. Review of the nursing narrative notes by LPN #1, LPN #2, noted that documentation was lacking of the coordination of services with the primary nurse, the Assistant Director of Behavior Health.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(3)(C)(D) Services.

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6. Based on clinical record review and staff interview it was determined that for Patient #s 5 and 23, the agency failed to conduct and/or failed to document that prior to the decision to discharge, a case review to determine the appropriateness of a premature administrative discharge was conducted which included patient care staff, supervisor/administrative staff, patient's physician, patient and/or the patient's representative; and/or that upon deciding to discharge the patient, the agency failed to inform the patient and/or family that services would be discontinued in ten days and the patient would be discharged from the agency. The findings include:

a. Patient #5 was admitted to the home care agency on 11/26/02 with diagnoses including paralysis agitans, atria fibrillation, organic brain syndrome and general osteoarthrosis. The physician plan of care for the certification period of 9/22/03 to 11/26/03 ordered skilled nursing visits 2 x per week to assess disease progress/decompensation, response to treatment, response to compliance to medications/side effects, assess changes in CP, GI, GU, skin, metabolic systems, mental status; and assess ability of caregiver to provide needed care and coping ability/family dynamics that impede care; home health aide services were ordered 2 x per day for 2 hours per morning, and 2 hour per evening for personal care and ADL assist.

i. Review of the nursing narrative note dated 9/18/03 documented that Patient #5's condition remained unchanged and family continued to refuse to discuss discharge, however, verbalizes understanding the need to decrease home health aide hours. When discharge is broached, the response is that Physician #1 will change Patient #5's medication. Telephone call to Physician #2, message left to decrease skilled nursing visits to every 2 weeks and decrease home health aide visits to 1.5 hrs per morning and 1hr per evening as this is what the patients needs are at this time. Documentation was lacking that Physician #2 signed the verbal order, dated 9/18/03, ordering this decrease in home health aide services.

ii. The nursing narrative note dated 9/22/03 documented that Physician #2's secretary left a voice message that Physician #2 wanted to know what "HHA and SNV" represented; RN #9 returned a voice mail phone call back to Physician #2's office to clarify the terms. RN #9 documented that the message left on 9/18/03 was to decrease the home health aide visits to 1.5 hrs per morning and 1 hr per evening and decreasing skilled nursing visits to every other week. RN #9 left her cell phone number and SCS #3's phone number for Physician #2 to return a phone call back if there was a problem with the change in the plan of care.

iii. The nursing narrative note dated 9/26/03 documented that Home Health Aide (H-HHA) #1 only provided a 44-minute visit to Patient #5 not the scheduled 1.5 hrs.

iv. The nursing narrative note of 9/30/03 documented that H-HHA #1 terminated voluntarily. The following nursing narrative note dated 9/30/03 identified that a discussion with the home

health aide department noted that 19 potential home health aides were reviewed and for various reasons could not provide staffing for Patient #1 on Monday through Friday mornings.
v. The nursing narrative note dated 9/30/03 by SCS #3 documented that she had a separate conference with the Director of Clinical Operations and Director of Reimbursement/Compliance to discuss the inability to provide Patient #5 with a morning aide and was advised to issue a 10-day letter of discharge with a recommendation of three agencies in the service area of the patient. SCS #3 documented that a conference with the Administrator was conducted and the Administrator was in agreement that a 10-day notice should be issued and to advise the patient's spouse and physician in reference to the above notice.
vi. Interview on 3/8/04 at 1:30pm with RN #9 stated that on several occasions she attempted to broach the discussion of discharge with Patient #5's wife, and each time the wife would refuse. Patient #5's wife would state the Physician #2 would change his medications to justify skilled visits. RN #9 stated that she did leave a phone call voice message to Physician #2 on 9/18/03 concerning the decrease in home health and skilled nursing visits, but did not speak directly with Physician #2. RN #9 stated that she was not involved with the decision to issue a 10-day premature discharge notice.
vii. An interview was conducted with SCS #3 at 11am on 3/8/04 and it was stated that several attempts were made to contact Physician #2 for a case review, but were unsuccessful and identified that only phone voice messages were left.
viii. An interview was conducted with Physician #2 on 3/8/04 at 3:10pm and it was stated that he (Physician #2) was unaware that a voice message was left by RN #9 on 9/18/03 that home health aide services were to be reduced; and there was never a conference held between the agency, patient/family and himself prior to receiving the agency's plan for a premature discharge for Patient #5; Physician #2 had no input into the decision for the premature discharge of Patient #5. Prior to the decision to discharge Patient #5, the agency failed to conduct a case review which included patient care staff, supervisory and administrative staff, patient's physician, patient and/or patient representative to determine the appropriateness of a premature administrative discharge.

b. Patient #23's start of care date was 12/16/03 with diagnoses including paranoid schizophrenia, cocaine abuse, obesity and chronic hepatitis C. The patient was admitted from a behavioral health hospital after decompensating secondary to drug abuse and non-compliance with ordered medications. The physician's certification plan of care dated 12/16/03 to 2/13/04 ordered skilled nurse 10-14 times per week for medication administration and assessment of exacerbation of psychotic symptoms, to assess mental status, coping skills, substance abuse, medication compliance. Review of clinical record documentation during the period from 12/16/03 to

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12/18/03 determined that agency nurses visited the patient 1-2 times each day. Patient #23 was compliant with the plan of care until 12/18/03 when agency nurses could not locate her for a medication administration visit. Clinical record documentation on a non-visit progress note by RN #7 (PCN) dated 12/19/03 stated that the physician called to report that he was admitting the patient to the emergency room for elevated blood sugar of 700. The physician informed the home health agency that prior to her hospital discharge of 12/16/03 blood sugar tests revealed elevated blood sugar of 570. On 12/19/03 documentation by RN #5 stated that the mental health clinic called to say that the patient was admitted to hospital on 12/19/03 and to cancel home visits on 12/20 and 12/21/03. The agency contacted the hospital on 12/19/03 to request they be notified when the patient was discharged, however, the hospital failed to notify the home health agency that Patient #23 was treated and released from the hospital on 12/19/03. Documentation by RN #5 on a non-visit documentation note dated 12/22/03 stated that RN #7 informed her that the patient had been discharged from hospital on 12/19/03 and RN #5 contacted the patient's mother who confirmed that the patient had been home and arrived there "with a bunch of pills". On 12/22/03 and 12/23/03, RN # 4 attempted to visit the patient, but she was not home and was not found. On 12/24/03 RN #4 contacted the case manager at the physician's office and informed him that the patient was "on hold" because agency nurses could not find her. During the period from 12/24/03 to 12/31/03 there was no clinical record documentation to support that agency staff attempted to contact the patient. On 1/1/04 RN #5 documented that she was unable to locate the patient in order to visit. Clinical record documentation dated 1/5/04 stated that the patient could not be located since she was released from the hospital on 12/19/03 and she was being discharged from the agency that day. The discharge summary dated 1/5/04 stated that the physician was informed and agreed to the discharge. When interviewed on 8/5/04 SCS #2 stated that agency nurses tried to contact the patient several times, but may not have documented their attempts. On 8/6/04, SCS #2 gave the surveyor a supervisor's conference note with entries made on 12/29/03 and 12/31/03 stating that nurses had unsuccessfully attempted to contact the patient several times (dates of attempted visits were not documented). The final entry was 1/2/04 and stated the patient could not be contacted, a case review was held and the behavioral health clinic was aware of the plan to discharge the patient. When interviewed on 8/5/04 the agency behavioral health department manager stated that the agency did not attempt to inform the patient and/or her family of the discharge. The agency failed to conduct and/or to document that the case

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review included the physician and/or the patient and/or the patient's representative; and/or failed to notify the physician and/or the patient and/or her family ten days prior to the discharge from the agency.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D72(a)(3)(D)(ii) Patient care policies.

Plan of Correction Completion Date

7. Based on clinical record review, review of vendor documentation and physician and staff interviews it was determined that for Patient #4, the agency did not verify the qualifications of the wound care specialist whose services were provided to Patient #4 and therefore failed to provide services consistent with the physician's plan of care for a wound care specialist to assess the patient's wound. The findings include:

a. Documentation on the 1/23/03 nursing narrative notes for Patient #4 by RN #1 included wound to buttocks 3 x 4 cm, telephone call to physician for a wound care specialist to come

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1/24/03. On interview with RN #1 on 4/27/04, RN #1 stated that LPN #4 did make a joint visit to Patient #4 on 1/24/03.
b. An interview with Vendor #1's Compliance Officer on 5/4/04 was conducted at which time it was stated that the role of Vendor #1's nurses is to confirm, for insurance purposes, the stage of the patient's wound. Documentation submitted by the Compliance Officer on 5/4/04 at 4:15pm, noted that the nurse consultants, such as LPN # 4, might be contacted by outside referral sources to decide the type of mattress that best fits the needs of the patient and his/her wound. The Compliance Officer documented that Vendor #1 and its employees only treat the patients wounds by the placement of the alternating pressure mattress, that is the end to the wound care intervention; documentation of the existing wound is for internal business practice to ensure following Medicare guidelines.
b. Interview with Physician #1 on 5/18/04, it was stated that he was under the impression that a wound consult was to be provided for Patient #4, not just an assessment for an alternating mattress.
c. Interview with the Director of Clinical Operations on 5/18/04, it was stated that Vendor #1 did represent its services as wound care specialists and was utilized in that role by the agency. The agency failed to follow the physician's plan of treatment by failing to obtain an appropriate wound care consult for Patient #4, as ordered, to assess the status of the patient's wound and/or to make recommendations for treatment.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13- D73(b) Patient care plan.

Plan of Correction Completion Date

DATE(S) OF VISIT: March 1, 4, 8, 9, 2004 and August 2, 3, 4, 5 and 6, 2004 with additional Information received through September 28, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

8. Based on review of the clinical record, staff interviews and agency documentation it was determined that the agency failed to maintain the confidentiality of all information related to Patient #4 without prior written consent for its release to persons not otherwise authorized to receive it. The findings include:

a. Review of the nursing narrative notes dated 1/23/03 for Patient #4 by RN #1 documented wound to buttocks 3 x 4 cm, telephone call to physician for a wound care specialist to come 1/24/03. Interview with RN #1 on 4/27/04, it was stated that LPN # 4 did make the joint visit to Patient #4 on 1/24/03.
b. Interview with Vendor #1's Compliance Officer was conducted on 5/4/04 and it was stated that LPN #4 is an employee of Vendor #1 and that the role of Vendor #1's nurses is to confirm, for insurance purposes, the stage of the wound. Documentation submitted by the Compliance Officer on 5/4/04 at 4:15pm, noted that nurse consultants such as LPN #4 might be contacted by outside referral sources to decide the type of mattress that best fits the needs of the patient and his/her wound. The Compliance Officer documented that Vendor #1 and its employees only intervene in wound management by the placement of the alternating pressure mattress, that is the end to the wound care intervention; documentation of the existing wound is for internal business practice to ensure that they are following Medicare guidelines. Inclusive of the documentation submitted by Vendor #1's Compliance Officer was the agency's Plan of Treatment (HCFA 485) for Patient #4 for the certification period of 1/11/03 to 3/11/03 and the nursing narrative visit notes by RN #1 for Patient #4 for 1/24/03. The Medical Equipment Authorization and Acknowledgment Agreement was dated 1/30/03, six days following the visit by Vendor #1's Clinical Consultant, LPN #4. The agency failed to obtain written consent prior to the release of patient information to persons not otherwise authorized to receive such information.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D78(b)(4)(A) General requirements.

Plan of Correction Completion Date

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT B
PAGE 1 OF 13

December 2, 2004

William Sullivan, Administrator
New England Home Care
57 Plains Road
Milford, CT 06460

Dear Mr. Sullivan:

Unannounced visits were made to facility on November17, 18 and 22, 2004 by representatives of the Division of Health Systems Regulation for the purpose of conducting a Federal follow-up visit with additional information received through November 30, 2004.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by December 13, 2004 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted. Please be advised that the completion date for corrective action should be no later that December 10, 2004.

Please address each violation with a prospective plan of correction which includes the following components:

a. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, in-service program, repairs, etc.).

b. Date corrective measure will be effected.

c. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Victoria V Carlson, RN, MBA
Supervising Nurse Consultant
Division of Health Systems Regulation

VVC

c: Nurse consultant

Phone:
Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134

DATE(S) OF VISIT: November 17, 18 and 22, 2004 with additional information received through November 30, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. The administrator failed to organize and direct the agency's on going functions and to ensure the safety and quality of care rendered to patients and families based on the violations listed in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2) General requirements.

Plan of Correction Completion Date

Provider/Representative Title Date

DATE(S) OF VISIT: November 17, 18 and 22, 2004 with additional information received through November 30, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

2. The Supervisor of Clinical Services failed to ensure the safety and quality of clinical service rendered to patients and their families based on the violations listed in this document.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(e)(3)(A)(B)(C) General requirements.

Plan of Correction Completion Date

3. Based on clinical record review, medication policy review and staff interviews it was determined that for seven (7) of fifteen (15) patients the nurse failed to furnish specialized nursing skill to document inclusion of all pertinent information to identify specific medications that had been administered and/or pre-poured (Patients #s 29, 31, 32, 43, 51, 53 and 54). The findings include:

a. Patient #29's start of care date was 9/3/04 with diagnoses including diabetes mellitus type 2, hypertension, hypercholesterolemia and hypertension. Documentation on the certification plan of care dated 11/20/04 to 12/31/04 ordered skilled nurse one time per week to pre-pour medications and to assess/instruct vital signs, cardio/respiratory status, endocrine status and response to medications. Clinical record documentation indicated that during the period from 11/08/04 to 11/12/04 medications were pre-poured by agency nurses, however there was no consistent

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

documentation to indicate the specific medications and/or doses that were poured/administered and or the time frames for which they were pre-poured.

b. Patient #31's start of care date was 11/26/03 with diagnoses including iron deficiency anemia, type 2 diabetes mellitus, chronic airway obstruction, atrial fibrillation and hypertension. Documentation on the re-certification plan of care dated 9/21/04 to 11/19/04 ordered skilled nurse once weekly to administer and to pre-pour medications, also to assess vital signs, general condition, safety and response to medications. Clinical record documentation indicated that during the period from 11/08 to 11/17/04 medications were regularly pre-poured by agency nurses, however there was no consistent documentation to indicate the specific medications and/or doses that were poured/administered and or the time frames for which they were pre-poured.

c. Patient #32 had a start of care date of 3/12/03 with diagnoses including hypertension, chronic renal disease, anemia and depressive disease. The plan of care dated 11/1/04 to 12/30/04 included skilled nursing 1x a week x 9 weeks to pre-pour medications every week per current physician orders, assess response to medications and teach medication effects/adverse effects. Review of the nursing notes from 11/8/04 to 11/14/04 lacked documentation regarding the specific reference utilized when the nurse pre-poured the patient's medications. SCS #7 stated on 11/17/04 that the nurse should document the pre-pouring of medications on the medication administration record and/or visit note. The agency failed to have a specific policy for the pre-pouring of medications.

d. Patient #43 had a start of care date of 9/30/04 with diagnoses including diabetes, chronic renal failure and cancer of the lung. The plan of care dated 9/30/04 to 11/28/04 included skilled nursing 1-3x a week to pre-pour medications. Review of the nursing notes from 11/8/04 to 11/17/04 indicated that the nurse documented the pre-pours as every 7 days per current physician orders but lacked documentation identifying the specific reference and current date of the reference utilized for the pre-pouring of medications; the patient had medication changes on 10/27/04. SCS #7 stated that the nursing note format had been changed many times this past year and the source and date of the pre-pours may have been deleted from the current nursing note format. The nurse failed to document the specific reference utilized when pre-pouring the patient's medications.

e. Patient #51's start of care date was 2/26/04 with diagnosis including type 2 diabetes mellitus, angiopathy, hypertension, chronic renal failure, and asthma. Documentation on the certification plan of care dated 10/23/04 to 12/21/04 ordered skilled nurse visits one time per week to pre-pour medications and to assess medication effects. Clinical record documentation indicated that during the period from 11/08/04 to 11/17/04 medications were regularly pre-poured by agency nurses, however, there was no consistent documentation to indicate the specific medications

DATE(S) OF VISIT: November 17, 18 and 22, 2004 with additional information received through November 30, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

and/or doses that were poured/administered and/or the time frames for which the medications were pre-poured.
f. Patient #53's start of care date was 10/21/04 with diagnoses including congestive heart failure, hypertension, glaucoma, and arthropathy. Documentation on the certification plan of care dated 10/21/04 to 12/19/04 ordered skilled nurse one time per week to prep-pour medications and assess medication effects, changes in health status. Clinical record documentation indicated that during the period from 11/08/04 to 11/17/04 medications were regularly pre-poured by agency nurses, however, there was no consistent documentation to indicate the specific medications and/or doses that were poured/administered and or the time frames for which the medications were pre-poured.
g. Patient #54's start of care date was 9/23/04 with diagnoses including aortic atresia/stenosis, congestive heart failure, angina pectoris and hypercholesterolemia. Documentation on the certification plan of care dated 9/23/04 to 11/21/04 ordered skilled nurse weekly to pre-fill medication box and to assess/instruct general condition, medication regime and effects. Clinical record documentation indicated that during the period from 11/08/04 to 11/17/04 medications were regularly pre-poured by agency nurses, however, there was no consistent documentation to indicate the specific medications and/or doses that were poured/administered and or the time frames for which the medications were pre-poured.
h. Review of the agency's medication administration/pre-pour policies, determined that medications administered by agency staff must be clearly and fully documented in the patient's medical record, but did not address documentation of medications that were pre-poured.
i. When interviewed on 11/17/04 the supervisor of clinical services of the West Hartford Office stated that a monthly medication administration record (MAR) is regularly used when medications are administered or pre-poured for psychiatric patients, but that documentation practice was discontinued for medical patients.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(2) Services.

Plan of Correction Completion Date

DATE(S) OF VISIT: November 17, 18 and 22, 2004 with additional information received through November 30, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

4. Based on clinical record review and staff, physician, Protective Service and family interviews, it was determined that for two (2) of twenty seven (27) patients, the primary care nurse failed to accurately, consistently and/or comprehensively re-assess the patient and/or to take prompt action and/or to intervene appropriately as the patient's health and safety status deteriorated; and/or to document the patient's immediate health care needs; and/or to notify and/or to follow-up with a prior communication regarding a change in condition that suggested a need to alter the plan of care and/or to update the plan of care, including the interventions to address changes in the patient's condition (Patient #s 38 and 40). The findings include:

a. Patient #38 had a start of care of 10/07/04 with primary diagnoses of urinary retention with an indwelling foley catheter, surgical procedure on 09/01/04 for paraesophageal hernia and

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

secondary diagnoses of Parkinson's disease, osteoporosis and esophageal reflux. The patient was alert, oriented and not conserved. The initial certification dated 10/07/04 - 12/05/04 ordered skilled nursing, physical therapy and occupational therapy two (2) times a week and stated the patient had a private 24-hour aide. On 11/04/04, LPN #5 documented the patient was ambulatory using a walker, had cloudy urine however his condition was status quo.

i. On 11/08/04, RPT #1 documented the patient tired easily secondary to an incident the evening of 11/07/04 where he fell attempting to get out of bed; the patient summoned 911 who checked him and assisted him back to bed; the patient declined to get out of bed and ambulate for RPT #1; RPT #1 reported the patient was home alone during her visit (11:15 - 11:50 am) and the night before when he fell. RPT #1 documented she left a telephone message for the son to confirm the patient's fall and being alone. RPT #1 documented the son did leave her a voicemail message at 6:45pm on 11/08/04. On 11/09/04, RPT #1 left another message for the son to call her during the day. RPT #1 wrote she discussed the patient's fall with RN #6 and OT #1 during an 11/08/04 case conference.

ii. On 11/08/04 at 12:30pm, RPT #1 faxed a copy of her visit report to the physician's office, as she was unable to reach him by phone. At 5:10pm on 11/08/04, the physician faxed back to RPT #1 asking "Is the patient appropriate in present setting from your point of view?" RPT #1 documented a late entry on 11/23/04 that she called the physician and left a message (date unknown) that the agency did not feel the patient should be at home unless he had 24-hour supervision. There was no clinical record documentation RPT #1 discussed with the physician the sudden deterioration in the patient's status and the need to change the plan of care. On interview on 11/30/04, the physician stated he was not made aware of the sudden deterioration in the patient's ability to ambulate, from 11/04/04 to 11/08/04; nor did he ever speak with anyone from the agency concerning changing the patient's plan of care. He recollected that his staff told him that the agency questioned the need for increased care at home and he faxed the agency a question concerning the appropriateness of the patient in his current setting.

iii. On 11/08/04 RN #6, the primary care nurse, documented she received telephone calls from RPT #1 and OT #1 reporting the patient was alone at night, had fallen and was unable to ambulate. RN #6 documented RPT #1 was to inform the family they needed to address 24-hour supervision; if they (family) choose not to act on this issue, the agency would contact Protective Services. On interview on 11/22/04, RN #6 stated that she telephoned the patient's son and recommended SNF placement due to his father's inability to get out of bed, increased fall risk and inability to reach the phone. RN #6 stated it was on 11/08/04 that she learned the patient did not have an aide 24 hours a day.

iv. On 11/09/04 the following transpired: LPN #5 visited the patient and documented she found the patient in bed, home alone, unsteady gait/fall risk, clear urine and unable to reach his

telephone. RN #6 documented she received a report from LPN #5 with her findings. RN#6 documented she discussed with SCS #6 about a plan to converse with the family further concerning the unsafe situation. RN #6 then left a voicemail message for the patient's physician concerning safety concerns. When interviewed on 11/22/04, RN #6 stated she did not follow-up with the physician concerning the patient's deteriorated status. RN #6 also left a voicemail message for the son informing him his father either needs 24-hour helpers or placement; if the son did not implement a plan quickly, the agency would contact Protective Services. On interview on 11/22/04, RN #6 stated she felt the situation was unsafe and urgent, however she did not complete a comprehensive assessment for the change in condition nor did she change the patient's plan of care to meet the needs of the patient nor did she request/initiate the services of their medical social worker.

v. On 11/09/04, OT #1 documented the patient was home alone and needed to have a bowel movement; refused a bedpan; wheelchair couldn't fit through bathroom; difficult transfer of one to and from commode. On 11/10/04, OT #1 notified the physician's office about the patient's home situation with decreased supervision at times. There was no clinical record documentation that OT #1 followed up with the physician concerning the home situation.

vi. On 11/10/04 at 12:30 pm, RPT #2 documented she found the patient in bed, home alone and unable to reach the telephone. RPT #2 wrote she communicated her visit findings to RPT #1.

vii. On 11/10/04, RN #6 documented she received a call from the physician's office agreeing that the patient needed 24-hour supervision. RN #6 then left another message for the son, who had left three (3) messages for RN #6. SCS #6 documented that at 1:50pm she and RN #6 called Protective Services with a referral for safety concerns as "the patient lives alone; has sporadic aide help during the daytime; incontinent of stool; has a foley catheter; cannot get out of bed without assistance; unable to reach phone in case of emergency; MD aware and agrees patient requires 24-hour supervision; family aware of safety concerns; patient refuses to be placed". On 11/10/04 RPT #1 spoke to her supervisor regarding the need for Protective Service due to the patient's safety. RPT #1's supervisor documented RPT #1 was to discuss the Protective Service referral with RN #6 and SCS #6.

viii. At 4pm on 11/10/04, RPT #1 received a call from the patient's son. He confirmed the patient's fall on 11/07/04 and that he had "Lifeline" that is setup for the son to be contacted first. RPT #1 expressed concern about the amount of time his father is left alone as he cannot get up by himself. The son told RPT #1 he recently had increased the aide service from 4 - 5 hours/day to 7 - 8 hours/day and was comfortable with this as the aide is very committed to his dad. RPT #1 questioned whether he and his brother would consider increasing the aide time, possibly supplementing temporarily with an aide from the agency, with a long-term plan for a 24-hour live-in. The son responded he would consider increasing the aide time and he did not want his

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

dad in a nursing home. RPT #1 documented she left a message for RN #6 about her conversation with the son.

ix. On 11/11/04 at 9:30 am, LPN #5 visited the patient and documented that she found the patient "non-ambulatory/fall risk, bowel incontinence/BM formed on 11/10/04"; the patient had "cancelled his MD appointment because he said he was dead weight and too heavy for the aide to lift him". LPN #5 documented the "patient refused 911 services to be evaluated by a doctor because he had decompensated in the past two weeks". The patient was home alone, without his Lifeline on and no phone by his bedside. LPN #5 documented she called the son but did not receive a call back from him.

x. On 11/12/04 at 1:50 pm, OT #1 called the patient and he refused a home visit. There was no reason documented as to why he declined. On 11/12/04, RPT #2 visited the patient and found him to be non-ambulatory, however he demonstrated improved sitting balance and was able to tolerate active exercises well.

xi. There were no home visits by any employee of the agency on 11/13/04, 11/14/04 and 11/15/04.

xii. On 11/16/04, SCS #6 and LPN #5 made a joint home visit. LPN #5 documented the patient was ambulatory with a walker; the patient reported his Foley catheter was removed on 11/15/04 and he was voiding without difficulty. SCS #6 documented a late entry on 11/23/04 that the patient had on three diapers; all were dry; he was home alone; he needed increased supervision in order to stay at home; he should expect someone to come out and assess him. There was no documentation by LPN #5 as to why or who removed the catheter. On interview on 11/22/04, SCS #6 stated she did not know who or why the catheter was removed nor did she contact the doctor concerning this. On 11/16/04, RPT #2 visited the patient and documented his catheter was removed on 11/15/04; improved sitting balance; transferred sit to stand with moderate to maximum assist if one; unable to ambulate without assist.

xiii. On 11/17/04 LPN #5 made a visit to the patient to deliver medications; no other nursing interventions were documented.

xiv. On 11/18/04, LPN #5 visited the patient and documented the patient was non-ambulatory; unsteady gait/fall risk; diaper was changed every two hours; she spoke with the private aide about spending more time cleaning the patient's feet as there was dirt between his toes.

xv. On 11/18/04 SCS #6 documented she spoke with Protective Services who visited the patient on 11/16/04 and they were in agreement the patient needed more supervision to stay at home. Protective Service spoke with the patient's son who was willing to make changes; private aide hours were increased to include overnights.

xvi. On interview on 11/24/04 the Protective Service worker stated SCS #6 told her the son wouldn't listen to them concerning his care, however the worker found the son amiable; willing

DATE(S) OF VISIT: November 17, 18 and 22, 2004 with additional information received through November 30, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

to supplement his private aide with an aide from the agency; the son didn't realize his dad was eligible for an aide from the agency; two days earlier the son had increased the private aide hours; the private aide had put three diapers on the patient because the catheter had been removed the day before. The Protective Service worker stated she asked SCS #6 why the agency wasn't utilizing their social worker. SCS #6 responded they wanted Protective Services involved. The Protective Service worker stated the son appeared to be on top of his dad's care; the son had played telephone tag with the agency on several occasions; the son sounded surprised the Protective Service worker had visited his dad.

xvii. On 11/19/04 at 9:10 am, OT #1 called RPT #2 questioning the caregiver's ability to do transfers and toileting in the bathroom. OT #1 attempted to make a home visit at 9:30 am and learned from the patient's neighbor that the patient was taken to the hospital the previous night. OT #1 called the son and learned the patient was short of breath when the son visited late last night. SCS #6 documented on 11/19/04 she called the hospital to check on the patient's status and learned the patient was admitted with pneumonia, atelectasis, sepsis and question of UTI. Hospital ER visit note of 11/19/04 documented chief complaints of "got SOB today with some abdominal pain" and "I don't feel well"; diagnosis of pneumonia; narrative notes stated history of present illness included "usual state of health until about 1 week ago when he wasn't feeling well"; assessment/plan included leukocytosis, hypotension ? sepsis and DM I.

xviii. On interview on 11/22/04, SCS #6 stated as of 11/10/04 she was the case manager; RN #6 was no longer available. It was her decision to continue to have LPN #5 visit the patient because LPN #5 was part of the team and it would have been difficult to get another RN. SCS #6 stated she did not increase nursing visits to assess the patient nor did she ever speak with the sons or the physician. SCS #6 stated she tried to call the physician, but the phone was always busy; she made no further attempts to contact the physician. A referral to the agency medical social worker was not made by SCS #6 because she "never thought of utilizing a MSW nor did she feel this was an appropriate case for a MSW". SCS #6 stated she did not complete a comprehensive assessment for the change in condition nor did she change the patient's plan of care to meet the needs of the patient. Her "plan was to wait for the family to act and for Protective Services to evaluate the patient before making any changes to the patient's plan of care". On interview on 11/22/04, RN #6 stated on 11/08/04 she didn't think about medical social service nor did her supervisor (SCS #6) suggest that to her.

xix. On interview on 11/24/04, the son stated that in early November 2004 he spoke with OT #1 who "had some concern if my dad needed 24-hour care, but she was satisfied with my plan of 7 - 8 hours/day, which was dispersed throughout the day, for the private aide. No one told me in early November dad wasn't able to take care of himself". He stated OT #1 told him she would share this information with the RN; OT #1 would keep him appraised; RN would call him with

DATE(S) OF VISIT: November 17, 18 and 22, 2004 with additional information received through November 30, 2004.

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

any changes. The son stated since the RN did not call him anymore, he assumed he didn't need to change the aide hours. He stated "out of the blue Protective Services called me and said the agency was appalled with the quality of care my father was receiving; his dirty feet; he was found wearing three diapers; need for 24-hour care". The son stated he was "not told the agency was calling Protective Services with a complaint; if only the agency had called me to tell me the problems; I was in the process of getting him a live-in; the agency jumped the gun". The son stated he was never told the agency had a medical social worker that could assist him in planning his father's care. At the beginning of his father's care by the agency, he was told about a home health aide, but preferred the private caregiver at that time. The son stated if the agency offered an aide again, it didn't leave an impression on him until Protective Services offered it.
xx. The nurse failed to complete a comprehensive assessment of the patient's change in condition, and/or to take prompt action and/or to intervene appropriately as the patient's health status deteriorated. The nurse failed to effectively communicate with the physician regarding the patient's sudden inability to ambulate and/or to adjust the patient's plan of care to be reflective of his needs based on his current health status and consequently left the patient at home in an unsafe situation, putting him at risk. The nurse also failed to communicate with the physician to initiate medical social services to assist in short and long-term planning.

b. Patient #40 had a start of care date of 9/28/04 with diagnoses including decubitus ulcers, diabetes, end stage renal disease and hypertension. The interagency referral form from the hospital dated 9/27/04 stated that the patient was anxious and depressed and went to hemodialysis 3x a week; the patient was to test her blood sugars tid with a coverage scale although no scale was identified.
The physician's plan of care dated 9/28/04 included skilled nursing 3x/wk x 1wk, 2x/wk x 2 wks and 1x/wk x 6 wks to A/I/S general condition, safety, LOF, medication regime, side effects/response and compliance, diet, coping mechanisms, blood sugars taken qd. by the patient and CV and pain statuses. The nurse was to provide wound care.
The wound care specialist noted in her nursing note of 10/28/04 that the patient reported to her that she fell the previous evening and went to the ER. The clinical record lacked documentation to support that the fall was reported to the primary care nurse.
The nursing note of 11/4/04 indicated that the patient reported to the primary care nurse that she had fallen in her bathroom last week due to a low blood sugar and was sent to the ER; the nurse documented that she reviewed diet and snacks; FBS reported by the patient was 85. Review of the incident report of 11/4/04 stated that the patient fell in the bathroom on 10/27/04, was evaluated in the ER and sent home without any changes in her medications. The patient had

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT C

August 26, 2005

Lee Rayzer, RN, Administrator
New England Home Care
57 Plains Road
Milford, CT 06460

Dear Ms. Rayzer:

Unannounced visits were made to New England Home Care on June 22, 23, 24, 28 and 29, 2005 by a representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a survey inspection with additional information received through August 23, 2005.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for September 9, 2005 at 10 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Victoria V. Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SNC:NC: A. Komarow, RN

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: June 22, 23, 24, 28 and 29, 2005 with additional information recieved through August 23, 2005

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(b)(4)(A) General requirements.

1. The governing authority failed to assume responsibility for the services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 6, 8, 15, 18, 20, 21, 22 and 25 and their families based on the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68(d)(2) General requirements.

2. The administrator failed to organize and direct the agency's on going functions and to ensure the safety and quality of care rendered to Patient #s 6, 8, 15, 18, 20, 21, 22 and 25 and their families based on the violations listed in this document.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D68(e)(2),(3)(B)(C) General requirements and/or D76(f)(1) Quality assurance program.

3. The supervisor of clinical services failed to assume responsibility for maintaining the quality of clinical services rendered to patients and families by direct service staff under their supervision and/or failed to effectively supervise the clinical competence of assigned nursing personnel and/or failed to directly evaluate the clinical competence of assigned nursing personnel as evidenced by the care and services rendered to Patient #s 6, 8, 15, 18, 20, 21, 22 and 25 based on the violations listed in this document.

4. Based on personnel record review, complaint log review, incident report review, agency policy review and staff interviews, it was determined that for RN #1 and RN #5 the supervisors of clinical services failed to adequately coordinate, manage and/or supervise all nursing personnel in the delivery of nursing services to ensure and maintain the quality of clinical services provided to patients and families. The findings include:

a. RN #1: Review of Patient #8's clinical record identified RN #1 as the patient's 11pm to 7am home care nurse since 09/13/04. Patient #8 was born 09/15/03 with tracheobronchialmalacia necessitating a tracheotomy, gastrostomy tube and was ventilator dependent.

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THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

i. Review of RN #1's personnel file indicated that on hire, 04/13/03, RN #1 documented on her skill and experience inventory list that she had no experience in ventilator management. In January 2005, RN #1 documented on her skill and experience inventory list she was very experienced in ventilator management. Review of the agency's RN/LPN skills assessment policy stated no staff member may perform a procedure independently in the field unless they have marked very experienced. There was no personnel file documentation to validate the accuracy in RN #1's documentation of 1/05 that she had become very experienced in ventilator management.

ii. Review of RN #1's six (6) months (11/12/03), twelve (12) months (04/13/04) and annual (05/18/05) job description and competency based performance appraisals did not include RN #1's ability to perform ventilator management. The agency required the private duty nurse to complete the annual self "Modular Education Program" each year. Ventilator management was not included in the program.

iii. Review of the agency's performance evaluation stated competency is evaluated based upon key performance requirements identified by the organization as relevant to each staff position. These key requirements can be evaluated through observation, demonstration, skills assessment, interview and documentation. Competency evaluation is a process that begins at hire and continues throughout employment. The agency is to assist in designing staff development activities appropriate to the needs identified. There was no personnel file documentation indicating RN #1 was in-serviced in ventilator management prior to her assignment to any pediatric ventilator dependent patient.

iv. Review of RN #1's resume indicated she did not have any ventilator management experience and little pediatric nursing experience. RN #1 stated on interview on 07/01/05
she had taken care of a few hospital-based patients who had had radical neck surgery, in the 1970's, who were on ventilators.

v. Review of the agency complaint log dated 03/18/05, identified that SCS #1 (private duty nursing supervisor) described a quality of care complaint from Patient #8's mother concerning the night nurse not knowing how to change the ventilator tubing and reporting an incident of the night nurse changing the tubing and not resetting the ventilator settings. SCS #1 documented the resolution as "setting up an appointment for ventilator tube changing for 03/30/05 at 8:00am at the patient's home". Interview with SCS #1 on 07/01/05, she felt the incident should be documented in the complaint log after having told the patient's mother about the in-service to be conducted in the patient's home; the mother hadn't made a complaint.

vi. On interview on 06/29/05, SCS #1 stated shift nurses are oriented to regular home care but there is no formal policy to orient private duty nurses (PDN) nor is there a skills requirement. SCS #1 stated that until recently, private duty nurse skills proficiency was done by phone. SCS #1 was not aware of RN #1's lack of ventilator management training until 03/17/05 when she learned that RN #1 failed to turn the PEEP (positive end-expiratory pressure) valve from zero back to ten (10). SCS #1 stated she did not go out the next night to instruct RN #1 because she trusted the first shift nurse's assessment (LPN #1), that the patient was at baseline. SCS #1 stated she allowed RN#1 to continue caring for the patient because she thought she rectified the situation by seeing to it that RN #1 would be in serviced on 03/30/05. SCS #1 instructed RN #1 to wake up the parents if there were any problems and to call her. SCS #1 stated she was employed as the PDN supervisor in January 2005; she was very experienced in ventilator management and was capable of training her staff. SCS #1 thought RN #1's

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01/05 skill and experience inventory list was accurate.

vii. Interview with the administrator on 06/29/05, she stated the agency has a "Private Duty Nursing Orientation Checklist" which included orientation to equipment management, however this form was not in RN #1's personnel file.

viii. On interview on 07/01/05, RN #1 stated that upon hire the agency did not provide her with any training related to ventilator management. RN #1 stated her requests to the previous SCS for training on ventilator management began on 09/24/04, but did not materialize perhaps because that SCS left the agency in 10/04. RN #1 did not know who her supervisor was from 10/04 - 01/05 before SCS #1 was employed. RN #1 stated she assumed the agency would schedule ventilator training for her. Patient #8 was her second pediatric ventilator patient at the agency. Her education concerning the first ventilator patient consisted of going to the hospital where she received a brief synopsis of the patient's hospital ventilator with no on-hands return demonstration. RN #1 stated she took care of that patient at home for two (2) or three (3) months during the 11pm to 7am shift. For Patient #8, RN #1 stated she observed the first shift nurse (LPN) for about an hour and a half, however RN #1 did not perform any on-hands care. RN #1 began caring for Patient #8 on 09/13/04. RN #1 stated that for both ventilator patients, she relied on the family if any problems developed. RN #1 stated if she had any ventilator related questions she would ask the day or evening shift nurses. She would contact her SCS if needed. She stated the two (2) previous supervisors never observed her in the home. SCS #1 first observed her at Patient #8's home on 03/30/05 during the training conducted by the ventilator equipment company.

ix. Interview with SCS #1 on 06/29/05, she stated Patient #8's parents were not informed that RN #1 was not trained in ventilator management. The parents wanted to be woken up whenever there was a problem. Interview with the administrator on 06/29/05, she stated she was not sure what the parents knew at the start of care, but the administrator thought the parents knew RN #1 was not trained in ventilator management. There was no clinical record documentation that the parents were aware and accepting of the fact that the 11pm - 7am nurse, RN #1, was not qualified in ventilator management and the parents wanted to be wakened if there was any problem.

x. Interview with the patient's mother on 08/23/05, she stated no one from the agency ever told her RN #1 had no training in ventilator management. She stated only after the surveyor came and read her son's record did SCS #1 tell her about RN #1's lack of experience; she would not have accepted RN #1 if she knew she was not trained in ventilator management. The mother also stated that when Patient #8 initially came home from the hospital, for a period of time, she slept next to him. She (mother) moved out of the patient's room when she found she was not sleeping well; she stated she told the nurses if they have a real emergency to wake her up. She stated the nurses should know what they are doing before taking care of a patient. The mother stated she assumed RN #1 and the nurses who took care of her son had experience in ventilator management and that she now asks now if the nurse is trained when a new nurse is assigned.

xi. The agency failed to maintain personnel records that included validation of RN #1's ability to provide skilled nursing services to ventilator dependent patients. The agency failed to document direct observation of clinical performance of RN #1 prior to 03/30/05 to ensure her proficiency with ventilator management. The agency failed to document in RN #1's personnel file her unsatisfactory performance on 03/17/05 and to develop a plan for corrective action. After learning on 03/17/05 that the 11pm -

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7am nurse was not trained in ventilator management, the agency failed to ensure that a nurse experienced in ventilator management cared for the patient on that shift from 03/17/05 thru 03/29/05 and/or that RN #1's proficiency in ventilator management was immediately established. The agency failed to assign, at all times, registered nurses who demonstrated competencies to monitor and assess both the patient and ventilator equipment to effectively meet the needs and ensure the safety of the patient at all times.

b. RN #5: Review of Patient #22's clinical record identified RN #5 as the patient's primary care nurse since the start of care of 01/06/05. Patient #22's primary diagnosis was depression and secondary diagnoses included alcohol dependency, diabetes type II, hypertension, asthma and acute pancreatitis.
i. Review of RN #5's personnel file indicated on hire, 09/14/04, that RN #5 was oriented to the medical record, which included documentation and medications. On 01/17/05, RN #5 documented on her skill and experience inventory list she was very experienced in all aspects of documentation. Review of Patient #22's clinical record from 01/06/05-03/07/05 found medication discrepancies between the physician orders and behavioral health skilled nursing notes. There were two (2) resumption of care certifications dated 03/08/05-05/06/05; RN #5 signed one and SCS #4 signed one, both dated 04/08/05.
ii. Interview with SCS #4 on 06/28/05, she stated she was RN #5's SCS from 01/03/05 thru 03/25/05 when RN #5 was employed as a behavioral health primary care nurse (PCN). SCS #4 stated it was difficult to obtain clinical record documentation from RN #5. It took weeks for RN #5 to submit the resumption of care recertification dated 03/08/05-05/06/05. SCS #4 stated she called RN #5 numerous times trying to obtain clinical record documentation. SCS #4 stated she learned that Patient #22's medical record was missing around 03/29/05; the record included original certifications, interim orders, a discharge summary and nursing notes thru 03/07/05. SCS #4 stated that to her knowledge, RN #5 was the last person to use the chart on 03/28/05. SCS #4 stated the record had to be reconstructed as best as possible. Certifications and comprehensive assessments were reprinted from the computer and duplicate nursing notes were obtained from payroll. The agency did not resend the physician orders for signature. The agency was unable to reconstruct the medication profile. SCS #4 stated she takes full responsibility for the missing chart, not ensuring the accuracy of Patient #22's medications and not ensuring that RN #5 submitted all clinical record documentation in a timely fashion.
iii. Interview with RN #5 on 07/14/05, she stated it was bothersome to her that the patient's chart was missing. RN #5 stated she specifically remembered writing the discharge summary because the patient was hospitalized and the certification period ended the next day. SCS #4 instructed RN #5 to rewrite the discharge summary using the new computer system, not hand written. RN #5 stated SCS #4 reviewed her documentation. RN #5 does not know what happened to the chart after that.
iv. Effective 03/26/05, RN #5 transferred to another unit within the agency where she became a medical PCN; the new unit territory was closer to her home. SCS #5 became her supervisor. Interview with SCS #5 on 06/28/05 she stated she was in contact with RN #5 often but did not have any tangible information from her as to where Patient #22's clinical record was. SCS #5 stated when she became RN #5's supervisor, she was not aware there were medication discrepancies in Patient #22's medical record.
iv. Review of the agency's PCN job description and agency policy and procedure stated the nurse must

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submit all admission paperwork within 24-48 hours, 485 recertificatons are to be complete, comprehensive and submitted timely.
Review of the agency's SCS job description stated the SCS monitors competency of professional staff on an ongoing basis and ensures timely and accurate submission of all paperwork. Review of the agency's performance evaluation stated competency is evaluated based upon key performance requirements that include observation, demonstration, skills assessment, interview and documentation. There was no personnel file documentation for RN #5 that SCS #4 and SCS #5 monitored RN #5's clinical record documentation for accuracy and timely submission.
v. Review of the agency's progressive discipline policy stated the best disciplinary measure is the one that does not have to be enforced and comes from good leadership and fair supervision at all employment levels. The major purpose of any disciplinary action is to correct the problem, prevent recurrence, and prepare the employee for satisfactory service in the future. Disciplinary action may call for any of four steps; verbal warning, written warning, suspension with or without pay, or termination of employment, depending on the severity of the problem and the number of occurrences. There was no personnel file documentation concerning RN #5's failure to submit clinical record documentation and documentation inaccuracies.
vi. The supervisor failed to conduct and/or to document ongoing monitoring of RN #5's competency with documentation accuracy and submission of clinical record documentation in a timely manner and/or any related progressive disciplinary measures to ensure complaince with agency policies.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69(a)(3)(D)(4) Services.

5. Based on clinical record review, staff interviews and agency policy review it was determined that for five (5) of twenty-six (26) patients, the nurse failed to accurately and/or appropriately re-evaluate the patient's status and/or to accurately document the re-evaluations of the patient's status and/or to notify the physician of a change in condition that suggested a need to alter the plan of care and/or to update the plan of care, including the interventions to address changes in the patient's condition (Patient #s 6, 8, 18, 20 and 21). The findings include:

a. Patient #6: During the period from 5/6/05 to 6/22/05 agency nurses regularly visited the patient and consistently documented that the patient's hygiene was poor and/or that his home was "filthy." Documentation by RN #2 (PCN) during the period from 5/7/05 to 6/22/05 repeatedly stated that she instructed him to shower and/or to clean the home, but that the problems re-occurred. There was no clinical record documentation to support that the nurse evaluated the patient for home health aide assistance.
During the period from 5/24/05 to 6/13/05 RN #2 consistently documented that the patient's behavior was inappropriate in that he would present in his underwear, that he went to the bathroom with the door open in her presence and that he would at times "invade her personal space." When these behaviors

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occurred the nurse instructed the patient that it was not appropriate and she documented that he was "safe to receive services." There was no clinical record documentation to support that RN #2 contacted the physician to report these problems and/or to collaborate about their significance to his disease process and/or to discuss care plan revisions to address the problems.
When interviewed on 6/24/05 RN #2 stated that she believed that the patient's dirty surroundings and his inappropriate behavior and dress were related to the patient's disease. RN #2 stated that she often felt uncomfortable and distracted when she was in the patient's home, but that she had not considered that it was not safe to provide services and/or that changing the plan of care could help better meet his needs. Agency nurses failed to accurately assess if Patient #6 was exhibiting exacerbation of symptoms related to his disease process and/or failed to alert the physician to his current status that suggested a need to alter the plan of care.

b. Patient #8 had a start of care of 08/04/04 with a primary diagnosis of tracheobronchialmalacia and secondary diagnoses including gastrostomy tube, tracheostomy and esophageal reflux. The patient was born prematurely at thirty-one (31) weeks gestation on 09/15/03 and was on ventilator support. Skilled nursing was ordered 4-24 hours a day, 3-7 times a week for cardio-respiratory and gastrointestinal assessments, medication administration, management of the tracheostomy, gastrostomy and ventilator. The physician's orders for the registered nurse also included instruct/teach the family in respiratory treatments, use/care of equipment/changing NG tube, positioning for feeding/checking for placement/patency of tube.
i. RN #1 documented in the clinical record on 03/16/05, 11pm-7am shift, that the disconnect alarm was sounding frequently; tubing intact; tubing changed; fell asleep at 1:15am; diarrhea five (5) times; apnea alarm sounding frequently; heart rate decreased to 59; alarm sounded at 3:30am and 3:45am; position changed and stimulated; heart rate running low 60's and occasionally higher; color good; skin warm; brisk capillary refill; heart rate decreased to 59 at 5:10am, 5:15am and 5:16am; respirations shallow; report to parents. On 03/16/05, RN #1 also documented the following: respiratory assessment coarse good airflow; cardiovascular assessment brisk capillary refill; gastrointestinal assessment abdomen soft, positive bowel sounds; skin warm, dry, intact; ventilator/apnea monitor assessment room air; oxygen saturation 100%; CPAP PEEP 10, PS 20; pulse 75; respirations 24. There was no clinical record documentation as to what time these values were obtained.
ii. LPN #1 documented in the clinical record on 03/17/05, 8:00am-4:00pm shift, report from dad, diarrhea all night; fussy this am; during ventilator check at 8:10am PEEP was found at zero (0); PEEP changed to ten (10) per doctor's orders; no respiratory distress noted; heart rate at 93. At 8:30am, LPN #1 documented respiratory assessment coarse, good air flow; cardiovascular assessment brisk capillary refill; gastrointestinal assessment abdomen soft, positive bowel sounds, diarrhea times one (1); skin warm, dry, intact. Ventilator/apnea monitor assessment room air; oxygen saturation 99%; CPAP PEEP 10, PS 20; pulse 93; respirations 42. No tracheostomy trials were attempted on 03/17/05 as the patient was to have a swallow test during this shift. LPN #1 called SCS #1 to report the PEEP setting had been off and her assessment that the patient was in no respiratory distress and had a heart rate of 93.
iii. RN #1 documented in the clinical record on 03/18/05, 11pm-7am shift, heart decreased to 59; mom notified; awake at 12am; quiet; moving about in bed. RN #1 documented between 3am-4am heart rate

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alarm sounding; heart rate decreased to 54; apnea alarm sounding; breaths per minute 7; mom notified; oxygen saturation 100%; color good; no signs and symptoms of respiratory distress; brisk capillary refill noted; rhonchi heard on expirations; albuterol treatment done by mom; suctioned by mom; moderate amount white mucus obtained after albuterol treatment; rhonchi still heard on expiration after albuterol treatment ; heart rate increased to 95-130; mom will call doctor in the am. RN #1 documented between 4am-6:30am patient sleeping; heart rate 65-90; breaths per minute 11-24; oxygen saturation 100%. There was no clinical record documentation the physician was notified of the respiratory episode that necessitated the mother administering an albuterol treatment and suctioning. RN #1 also documented on 03/18/05 pulse 67; respirations 14; respiratory assessment coarse good air flow; cardiovascular assessment brisk capillary refill; gastrointestinal assessment abdomen soft, positive bowel sounds; skin warm, dry, intact. Ventilator/apnea monitor assessment room air; oxygen saturation 100%; CPAP PEEP 10; PS 20. There was no clinical record documentation as to what time these values were obtained.

iv. RN #1 documented in the clinical record on 03/21/05, 11pm-7am shift, heart rate alarm decreased to 58-57 then increased to 65 maximum at 1am, oxygen saturation 100%; respirations 8-24; brisk capillary refill; color good; tried to call Physician #1 (pediatrician), message on voice mail said if an emergency call 911; did not call 911; called SCS #1 at agency and updated her; 8-4 nurse, LPN #1, to call Physician #1 with update; apnea alarm sounding frequently; patient is snoring and breathing shallowly; breaths per minute 10- 12 when alarm sounds; heart rate 58-65; low minimum volume alarm also sounding; position changed and stimulation done; call 911 if heart rate decreases more than present heart rate levels during the rest of the night per SCS #1; heart rate increased to 76 at 5:30am; report to dad; note left for 8-4 nurse, LPN #1, to update Physician #1 about decreased heart rate.

v. LPN #1 documented on 03/22/05, 9:15am, Physician #1 called as suggested by SCS #1 concerning decreased heart rate and shallow breathing overnight; Physician #1 suggested calling Physician #2 (pulmonologist), due to a respiratory issue. At 9:30am Physician #2 called; message left heart rate 57-60's and shallow breathing. At 1:30pm Physician #2 called; Physician #2 aware; due to unsymptomatic keep setting as is 60 heart rate; continue to monitor; if any other symptoms arise, let Physician #2 know.

There was no clinical record documentation that Physician #1 and Physician #2 were told about the PEEP being off on 03/17/05 between approximately 1:00am until 8:10am when LPN #1 identified that the PEEP was set at zero (0).

vi. Interview with Physician #2 on 07/02/05, she stated she was called on 03/22/05 by LPN #1 concerning decreased heart rate and shallow breathing but she was not informed the PEEP was off for 7-8 hours on 03/17/05 between approximately 1am and 8:10 am. Physician #2 stated the patient had begun trach trials for 1-2 hours a day when he was awake; when the patient sleeps is not the time for a trach trial. Physician #2 stated having the PEEP off could have been significant and might have been a contributory reason the patient's heart rate decreased, the shallow breathing and the need for an albuterol treatment with suctioning the following day, 03/18/05. Physician #2 stated she should have been notified the PEEP had been off.

vii. Interview with Physician #1 on 07/06/05, she stated she received a phone call from the agency concerning decreased heart rate and shallow breathing on 03/22/05 however she was not told the PEEP

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had been off for 7-8 hours on 03/17/05. Though she advised the agency to call the patient's pulmonologist, Physician #1, stated she should have been informed that the PEEP had been off. Review of the incident report dated 03/16/05, LPN #1 documented the physician was not notified the PEEP had been turned off after a tubing change.

viii. Interview with SCS #1 on 06/29/05, she stated the agency did not have any policies and procedures concerning ventilator management; however she had recently developed ventilator management policies and procedures which were to be formally presented to agency management on 07/12/05. Subsequent to surveyor inquiry, SCS #1 showed the surveyor a textbook entitled "Competency in Pediatric Nursing, A Modular Training Program", which included a module on mechanical ventilation. SCS #1 stated she had just obtained it from RN #3, the agency's director of quality improvement. SCS #1 stated she was not aware the agency had this teaching tool that could be used as the guide for ventilator management. Review of this procedure manual identified that effective ventilator management and documentation should include ventilator settings to be checked against physician's orders at the start of each shift, every two (2) hours, and PRN; settings should be documented on a ventilator flow sheet and nurses' notes. Between 03/01/05 and 04/07/05, RN #1 failed to document what time she performed the nursing assessment, obtained the vital signs and checked the ventilator/apnea monitor.

ix. The primary care nurse (PCN) for Patient #8 is SCS #1. All the certifications and plans of care ordered the PCN to visit one (1) time a month for supervision of the plan of care and the shift nurses. After learning by phone of the incident that occurred on 03/17/05, the PCN, SCS #1, did not make a home visit to assess the patient's status. SCS #1 stated on interview on 06/29/05 she trusted LPN #1's assessment that the patient didn't deviate from baseline and everything was ok; she did not feel a home visit was warranted. When SCS #1 was interviewed on 07/01/05, she stated LPN #1 made the judgment not to call the physician; she did not know it was not in the scope of practice for a LPN to make assessments and judgments concerning her findings. SCS #1 stated her role as the PCN was for case management. SCS #1 failed to ensure that the LPN provided services under the guidance and supervision of the RN at all times and within the scope of practice of the LPN.

x. Interview with RN #1 on 07/01/05, she stated in the early hours of 03/17/05, the disconnect alarm sounded on the ventilator monitor. She woke up the patient's paternal grandmother. RN #1 stated the grandmother helped assess the problem as to why the disconnect alarm went off. The grandmother determined it was the tubing that needed to be changed although the tubing was not disconnected nor was there water in the tubing. RN #1 stated she assisted the grandmother by handing her the tubing. RN #1 stated she was not sure what to do with the PEEP setting so she asked the grandmother. RN #1 did not document the grandmother's involvement. RN #1 was not sure if she checked the PEEP setting after the tubing change; RN #1 stated she checked the PEEP at the start of her shift.

Review of the clinical nursing notes from 03/01/05 through 04/07/05, identified the disconnect alarm sounded two (2) times, on 03/16/05 and 03/22/05, both during the 11pm - 7am shift while RN #1 was on duty.

Interview with RN #1 on 07/01/05, she stated during her shift on 03/18/05 the heart rate alarm and the apnea alarm sounded. She heard rhonchi on expiration. RN #1 stated she woke up the mother and asked her to assess/confirm if what she was seeing was correct. The mother immediately administered

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the albuterol and suctioned her son. The mother was to call the doctor in the morning. RN #1 stated the albuterol was administered by the mother only two other times during her shift; the mother showed her (RN #1) how to administer the nebulizer treatment.

xi. The primary care nurse, SCS #1, failed to re-evaluate the patient's status after learning the ventilator PEEP valve had not been turned back on for a significant amount of time. SCS #1 failed to ensure that all shift nurses were knowledgeable and understood mechanical ventilation so as to safely and accurately evaluate the patient's status. SCS #1 failed to ensure all shift nurses were capable of providing care but were also capable of training and evaluating the lay caregivers as ordered by the physician and/or to ensure that the LPN performed her duties within her scope of practice and under the supervision and dircetion of an RN at all times. The agency failed to notify the physician in a timely manner concerning the change in the patient's health status and failed to inform the physicians the PEEP had been off for 7-8 hours during the night of 03/17/05. See Tags G140 and G158.

c. Patient #18 had a start of care date of 5/16/05 with diagnoses including unsteady gait, mastectomy, anemia, Vitamin B deficiency, GI bleed and Parkinson's disease. The plan of care dated 5/16/05 to 7/14/05 included skilled nursing 3x a wk. x 1 wk, 2x a wk x 2 wks, 1 x a wk x 6 wks to administer Vitamin B-12 injection q month, assess knowledge of medications, s/s to report, mental/behavior, orientation, assess/instruct in nutrition/diet, hydration, assess stools for changes in color or blood and assess cardiopulmonary status;

refer for PT and OT; refer for home health aide 3x a week to assist with personal care, home exercise program (HEP) and prepare meals.

The summary to the physician on 5/16/05 stated that the patient was alert and oriented but forgetful, lived alone but had a supportive son who assisted her and pre-poured her medications. The patient's gait was unsteady, she experienced dyspnea on exertion (DOE) after ambulating 30 ft, she was to receive "meals on wheels" (MOW) and her appetite was fair. The nurse instructed the patient to increase foods with iron and her hydration. The patient denied blood in her stools but her stools were dark due to iron medication. The patient had a history of alcohol abuse; BP was 118/64.

The interagency referral form from the skilled nursing facility listed the patient's weight as 126 lbs., the patient had no evidence of active or occult bleeding and her BP range in the skilled nursing facility was 118/60 to 164/82.

i. The admission assessment by the nurse, which was not dated, indicated that the patient's weight was 119lbs. on the patient's scale and the patient's nutritional assessment was not numerically scored to assist in identifying a nutritional problem or potential problem for the patient.

Review of the clinical record between 5/16/05 and the nurse's discharge visit date of 6/15/05 indicated that the patient had lost 7 lbs. in 4 weeks. The nurse documented that the patient's appetite was fair and during her visits on 5/31/05 and 6/2/05 the nurse noted that the patient did not have any taste or smell. She noted that the patient received meals on wheels and demonstrated the ability to reheat meals. The clinical record lacked documentation to support that the nurse was aware of the patient's weight loss, had comprehensively assessed her nutritional status including amount of MOW food consumed, number of meals per day including breakfast, hydration status including adequate intake and output, the need for a dietary supplement; and/or meal preparation/weights and/or nutritional observations that

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needed to be added to the aide's care plan of 5/16/05. On her discharge note on 6/15/05 the nurse indicated that her goals were met, the patient continued with meals on wheels and that the patient's son would take her to the physician's office for her Vitamin B-12 monthly injection because the son was not comfortable in administering the injection. The clinical record lacked documentation that the physician was aware of the patient's weight loss on nursing discharge of 6/15/05; the patient's weight was 112 lbs. and her BP was 100/60, which was low for the patient.

The nurse failed to identify and/or accurately reassess the patient's nutrition and hydration status prior to discharging the patient from nursing for a patient who lived alone, had a prior history of ETOH abuse, was not able to cook or shop for herself, had an unsteady gait, was identified as having a fair appetite and no sense of taste. The patient's BP had also decreased and the aide's written care plan did not include nutritional interventions.

ii. The interagency referral form dated 5/15/05 from the skilled nursing facility listed the patient's diagnoses as severe anemia, GI bleed and Vitamin B-12 deficiency.

The patient 's medications included ferrous sulfate 325mg qd po.

Review of the clinical record from 5/16/05 to 6/15/05 indicated that the patient denied black/tarry stools and/or blood in her stools .The nurse reviewed s/s to report regarding bowel function. The conference note of 6/1/05 between the PT and nurse indicated that the patient's progress continued to improve somewhat but the patient continued to need a walker and PT reported an unsteady gait and fatigue. OT reported to the supervisor on his discharge of 6/3/05 that the patient required assist with a shower, could complete a simple meal for breakfast and required assist with ADLs.

The clinical record lacked documentation that any lab work had been completed for the patient in order to monitor her anemia prior to nursing discharge since the patient was taking an iron supplement which often masks the sign of blood in the stool; the patient's BP was also low on nursing discharge and she was somewhat fatigued; the patient was not going to see the physician until 6/23/05 for her Vitamin B-12 injection.

SCS #2 stated on 6/25/05 that the nurse discharged the patient since her nursing goals were met and the physician would be administering the Vitamin B-12 injection on 6/23/05 (the patient did not have a diagnosis of pernicious anemia); PT and home health aide were still active with the patient and the MSW was pursuing long term assistance for the patient.

Subsequent to surveyor's inquiry, SCS #2 submitted an addendum from the nurse on 6/24/05 which stated that she was aware of the weight loss and had been addressing the diet with the aide and patient. She stated the patient had resumed smoking and she told the patient that smoking decreases the appetite. She stated that when doing aide supervisions she instructed the aide on high protein foods etc. Review of the aide's care plan of 5/16/05 (that had not been updated) and aide's activity sheets did not include documentation of any interventions related to meal preparation, weight monitoring and/or logging of diet and/or fluid intake. The addendum stated that the nurse checked the refrigerator and freezer to assure that the patient had food and checked the garbage for alcohol bottles. The aide was to leave a meal in the microwave for the patient's convenience. The clinical record lacked documentation that the nurse assessed the patient's response to the nurse's dietary instructions and/or the son's and aide's response to dietary instructions and/or if any dietary interventions were being implemented i.e. a dietary log kept in the home, identifying percentage of consumption of meals on

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wheels, need for consultation with a dietician, addition of supplements etc. since the patient continued to lose weight and appetite was poor. SCS #2 stated on 7/6/05 that the patient's last lab tests were done on 4/25/05

Subsequent to surveyor's inquiry Branch Director #1 called the physician's office on 6/28/05 to request a copy of the patient's lab work relating to her Vitamin B-12 deficiency. On 6/30/05 Branch Director #1 called the physician and reported the patient's weight loss, that she received MOW, her resumption of smoking, PT, OT and aide services, the MSW's initiation for an application for state funding and nursing discharge of 6/16/05. The physician was unable to confirm a diagnoses of pernicious anemia since he had not seen the patient since her hospital discharge. On 7/6/05 SCS #2 noted on a case conference form that PT and aide services were being discharged on 6/30/05. A call to the patient's son on 7/6/05 indicated that the scheduled appointment to the physician on 6/23/05 was cancelled and Patient #18 and/or her son never made the rescheduled physician's appointment and he (the son) had to administer the patient's Vitamin B-12 injection himself; the son stated that he was hesitant regarding the administration of the injection but he did it without difficulty. SCS #2 instructed the son to monitor the patient's weight and meals daily and to notify the physician if the patient loses 3-4 lbs. in a week. SCS #2 recommended a follow-up physician visit for lab work to the son.

The nurse failed to accurately and comprehensively assess the reason for the patient's continued weight loss and nutritional status prior to discharge from nursing and/or failed to discuss with the physician the need to assess the status of the patient's anemia prior to discharge.

d. Patient #20 had a start of care date of 2/8/05 with diagnoses including physical therapy, abnormality of gait, diabetes, macular degeneration and hypertension. The home care agency's referral admission form indicated that the patient was referred from an assisted living facility with primary diagnoses of diabetes and hypertension and a secondary diagnosis of unsteady gait. The patient was identified on the referral form as a fall risk, alert and oriented to person with some confusion noted and unsteady when ambulating. The referral sheet did not indicate the onset dates for the patient's diagnoses and physical therapy was the only discipline requested.

The physical therapist (PT) admitted the patient on 2/8/05.

The memo of understanding with the assisted living services agency (ALSA) stated that PT would visit on Tuesday and Thursday and the RN in the ALSA would pre-pour medications, the ALSA aide would assist the patient 3x a week for showers, med cues and laundry.

The plan of care dated 2/8/05 to 4/8/05 included PT 2x a week x 9 wks to assess/evaluate exercise techniques, endurance/mobility training, gait training, bed mobility, teach environmental modifications for safety and fall risk reduction strategies. The PT was to assess pain, activity and coping strategies. The PT referred for OT on 2/8/05.

The summary to the physician, dated 2/8/05 stated that the patient was a new resident in the assisted living facility, demonstrated multiple concerns regarding balance, endurance, transfers and safety. The patient was unable to walk 200ft. with a cane, was unable to stand from a commode, was unable to get legs onto bed and she demonstrated a shuffling gait. The patient received assist for bathing through the ALSA and wanted to keep it that way. The PT stated that he was unable to assess the patient's VS due to it being mealtime.

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On his subsequent visit to the patient on 2/10/05, the PT documented that the patient was tired and the nurse in the ALSA reported that the patient had a urinary tract infection (UTI).
Review of the clinical record indicated that an order was sent to the physician on 2/10/05 for skilled nursing to make 2-3 as necessary visits for falls, change in health status or medications. On 2/10/05 a second order was sent to the physician for skilled nursing 2x a wk x 2 wks and 1x a wk for 7 wks to assess endocrine, GU, mental statuses and safety and supervise the aide 2x a month; home health aide was ordered for 3x a week x 9 wks to assist with personal care, ADLs and IADLs.
The clinical record lacked documentation as to the reason for the nursing referral on 2/10/05 and/or who referred for the nursing visit.
On her initial nursing visit of 2/10/05 RN #5 indicated that she was unable to assess the patient's weight because the patient was unable to stand on the scale. The patient exhibited trace BLE, denied symptoms of UTI, was oriented to name only, refused home health aide because she wanted to keep her ALSA aide and stated that she had been a diabetic for "a while" but had never checked her own blood sugars. The ALSA staff informed the nurse that a glucometer was ordered and that they requested the home care nurse to instruct the patient in its use. The record lacked documentation to support that the nurse did an integrated comprehensive/OASIS assessment of the patient related to a change in condition and/or any comprehensive assessment on her initial visit including confirming with the physician the onset dates of the patient's diabetes and hypertension.
A case conference note of 2/11/05 signed by the nursing supervisor, RN #5, stated that the patient had a new onset of increased edema to legs, TEDS stockings were on, Lasix as needed was ordered - effects pending, plan to teach glucometer use and PT and OT were involved. The record lacked documentation to support that a nursing visit was conducted until 2/14/05 to assess the patient's change in status. A nursing visit was made on 2/14/05 by RN #6 who indicated that the patient's BP was elevated, she exhibited +2-3 BLE with purplish color noted in both extremities, pedal pulses present and extremities cool to touch. The patient's lungs were clear and she denied shortness of breath (SOB). The patient was instructed to keep her legs elevated. The nurse called the physician to report the increase in BP and Lasix had been ordered prn daily for LE edema. The nurse was to follow up on 2/15/04 for the elevated BP. The nurse also sent a verbal order to the physician for Cipro 250 mg. bid for UTI. A conference note of 2/14/04 indicated that the nurse conferenced with the nursing supervisor who was also the patient's PCN regarding new findings in the patient's health status.
The agency's medication profile did not list the Lasix until 2/17/05 and the ALSA medication profile, which was in the agency's clinical record, did not list the Lasix prn.
The nursing note of 2/15/05 noted the patient's BP as130/84, lungs were clear, LE edema was a +1 with the right slightly more edematous than the left and soreness noted to the knee was reported. The nurse reviewed signs/symptoms of CHF to report (Patient #20 was confused at times). No signs of DVT were noted. The nurse conferenced with the physician regarding the edema and with the ALSA staff. An order was sent to the physician on 2/15/05 for TEDS stockings and Lasix prn.
On 2/17/05 the PT noted that the patient's LE edema was less because the patient was wearing support stockings but the patient had an increase in SOB, needed additional pillows on her bed and reported that she had fallen the other day.
The nursing note on the same day 2/17/05 noted that the patient reported that she had fallen in dining

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room while sitting down on a chair, complained of soreness in her right knee and had a large ecchymosed area to the left hand. The nurse initially assessed the patient's BS on 2/17/05 and found it to be 276 at 2 hours post prandial (pp).

The nurse noted on 2/17/05 a call to the physician regarding the patient's fall, elevated BS and that the patient refused an ER evaluation. She noted a new order for TEDS stockings and a Lasix prn order to decrease the edema (a previous order was sent on 2/15/05).

The clinical record lacked documentation to support that the nurse accurately and/or consistently assessed the patient's diabetic status and management including onset date, daily FBS; failed to assess the patient's weight, frequency of the administration of Lasix and/or s/s of CHF/dehydration; failed to accurately assess the patient's mental status in order to determine reasons for the patient's unsteady gait and change in health status and/or failed to follow through with the need for additional home health aide service.

On 2/18/05 Supervisor #5 conferred with the PCN #4 and noted a new diagnosis of "diabetes?" and it was doubtful if the patient could do her BS independently due to her being hard of hearing and visually impaired.

On 2/21/05 the RN #4 documented on a case conference form that the client had fallen on Friday 2/18/05 and sustained a fractured wrist and was admitted to an ECF.

The agency's clinical record lacked documentation to support ongoing communication with the ALSA regarding the patient's health status and if the fracture on 2/16/05 was the reason for transfer to the ECF.

On 6/28/05 RN #4 was interviewed to explain the sequence of events regarding Patient #20 since the clinical record was fragmented and lacked conference notes with the ALSA. She stated that the ALSA referred initially for PT only due to the patient's unsteady gait and she believed it was therapy who referred for nursing due to the patient's recent diagnosis of UTI; RN #4 was uncertain how the PT knew of the UTI. RN #4 stated that the patient wanted to keep her ALSA aide so she refused the agency aide but the physician was not informed that the agency would not be providing the aide service as ordered. RN #4 did not know how long the patient had been a diabetic or why the patient was experiencing lower extremity edema. Multiple nurses visited the patient. She stated that she was not aware of any parameters regarding the administration of the prn Lasix order or how often it needed to be administered as the Lasix was administered by the ALSA nurse. The ALSA nurse usually informed the agency nurse of medication changes. RN #4 was not sure why the ALSA did not notify the agency regarding the fall on 2/16/05 except that it may have occurred after hours. RN #4 stated that although conferences with the ALSA had not been documented clearly in the clinical record, agency and ALSA conferenced frequently.

The ALSA supervisor stated on 6/29/05 that the patient had just been admitted to the ALSA on 2/7/05. She referred to the home health agency for PT only on 2/8/05 because on pre-admission, the patient had tested very well and was not identified as a fall risk and when she was tested again on 2/7/05 her status had dramatically changed and she did not do well. The ALSA supervisor stated that the physician and/or the family had not completed the onset dates of the patient's diagnoses so she was not certain of the patient's onset date of her diabetes. She stated that the ALSA nurse had sent the patient's urine for a C&S due to symptoms/incontinence and the patient was started on Cipro, however that was not the

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reason the patient was referred for nursing from the home health agency. The ALSA supervisor referred for nursing due to a change in the patient's health status including increased lower extremity edema, incontinence and she wanted the patient to have increased aide services and a nursing assessment. The ALSA supervisor stated that the patient would not have had to give up her ALSA aide if she received an aide from the home health agency and the home care nurse should have been aware of this fact. The ALSA nurse weighed the patient on admission and on 2/9/05 and 2/15/05 and noted she had a 3lb. weight gain (the patient was able to be weighed using her walker) and only one dose of prn Lasix was administered on 2/15/05. The patient fell in the dining room on 2/16/05 when she was using a chair with wheels. The physician was notified and no changes in orders were noted. The patient went out with her son on 2/18/05 and fell in her room upon her return; her son present during the fall The patient went by ambulance to the hospital where she was diagnosed with a fractured wrist and was sent to an ECF.
The ALSA supervisor stated that the patient was "new to us in the ALSA, we were just getting to know her and we identified that the patient's health status was changing quickly and therefore we referred to the home health agency to assist us with her care".
The nurse failed to accurately and/or consistently assess/reassess the patient's changing health status and/or to complete a comprehensive assessment when a significant change in condition occurred i.e.: obtaining an accurate health history, assessing her fluctuating CP status, diabetic status/management, mental status, functional status and/or failed to refer for additional aide service for a patient who exhibited a decline in her functional status.

e. Patient #21: Clinical record documentation by RN #6 on the OASIS/comprehensive assessment dated 4/22/05 stated that the patient was a low nutritional risk with no ingestion problems identified. Clinical record documentation by the ST dated 4/25/05 stated that the patient ate ground foods and thick liquids, but there was no documentation to indicate that the patient had dysphagia. When interviewed on 7/12/05 ST #1 stated that the physician ordered speech therapy for education and training of the patient and caregivers to the communication device and that she did not evaluate this patient for dysphasia except to observe him eating for about five minutes as he finished a meal. ST #1 stated that she gave the day care instructors a generic feeding plan for persons being fed at a 90-degree angle because it was appropriate for the patient's situation.
RN #5 documented on a case conference form dated 6/3/05 that the case manager from the Department of Mental Retardation (DMR) called to report that the patient had been sick for the previous 10 days with aspiration pneumonia and cough and that he was treated at the emergency room. RN #5 documented on 6/3/05 that she contacted the patient's father who reported that the patient had been treated with antibiotics and that he was better and not coughing. Documentation by RN #5 on the same note stated that she instructed the father regarding aspiration precautions, to only give pureed foods if "OK" with the physician, to take the patient's temperature daily and to call the physician and/or nurse with temperature greater than 100 and/or increased coughing. RN #5 documented on 6/3/05 that she contacted the physician and left a message to inquire about any changes of treatment, however, there was no clinical record documentation that she revisited until 6/6/05.
On that date RN #5 documented that the patient was not home/not found.

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RN #5 did not revisit until 6/8/05 (Wednesday) and documented in the nurse visit note that the gastro-intestinal system was within normal limits, but that the a modified barium swallow was done the previous Friday (6/3/05) and that the physician recommended a gastric tube and Metronidazole was ordered for aspiration. On 6/8/05 RN #5 documented that she called the physician because he had not responded to her call of 6/3/05 and expressed the necessity to discuss the patient's changed status and possible changes to the care plan including a speech therapy evaluation and/or additions of thickener to foods/fluids. There was no clinical record documentation to support that RN #5 assessed the patient's ability to swallow, the PCG's ability to feed the patient and/or the patient's nutritional intake. RN #5 documented a revisit on 6/10/05, but stated that nutrition was within normal limits and that the PCG would continue to feed the patient. RN #5 documented on 6/13/05 that she spoke with the physician's office staff and was informed that the results of the modified barium swallow were not ready yet. RN #5 informed the office staff that the PCG and family were refusing the G-tube at this time and continued to feed the patient, but that the PCG reported "no elevated temperature or coughing". On 6/16/05 RN #5 documented a case conference with the agency supervisor of clinical services and stated that the patient was at risk for aspiration and that RN #5's plan was to case conference with the physician and the PCG regarding the medical necessity for G-tube placement. On 6/14/05 RN #5 contacted the speech therapist about the patient's changed condition and she arranged a family meeting with case conferences including the physician and the DMR social worker. However, during the period from 6/10/05 to 6/20/05 there was no clinical record documentation to determine that RN #5 revisited to evaluate the patient's status and/or that she revised the plan of care to assess the PCG feeding, the patient's swallowing and/or to implement interventions aimed at minimizing the risk of aspiration. Documentation on 6/20/05 by RN #5 determined that the physician's opinion was that Patient #21 could not safely consume food/fluids unless through a G-tube. Documentation by SCS #3 on a case conference form, dated 6/20/05, stated that after RN #5 informed her of the patient's status, skilled nurse visits were increased to twice weekly to assess aspiration risk, cardio-pulmonary status and pulse oximetry.

When interviewed on 6/29/05 SCS #3 stated that the PCN no longer worked for the agency. SCS #3 stated that after reviewing this case she concluded that the nurse should have re-visited the same day that she learned that the patient had aspiration pneumonia and she should have appropriately increased the skilled nurse visits at that time.

Agency nurses failed to accurately and appropriately re-evaluate the patient when he developed aspiration pneumonia and/or failed to re-visit appropriately in order to assess the patient's swallowing ability and/or food intake and/or when the patient's status changed agency nurses failed to alter the plan of care to address his needs.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73(b) Patient care plan and/or D72 (a)(1)(F), (2)(D) Patient care policies.

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6. Based on clinical record reviews, agency policy review and staff and physician interviews it was determined that for six (6) of twenty-six (26) patients the nurse failed to follow the written plan of care/orders as established by the physician (Patient #s 6, 8, 15, 18, 21 and 25). The findings include:

a. Patient #6's start of care date was 9/8/04 with diagnoses including paranoid schizophrenia, pedophilia, hypertension and esophageal reflux. Documentation on the recertification plans of care dated 3/7/05 to 5/5/05 and 5/6/05 to 7/4/05 ordered skilled nurse 14 times per week for assessment of exacerbation of symptoms, base knowledge of level of disease, potential contributing and causative factors; to pre-pour medications, assessment of medication effects, responses to medications and teaching to implement reminder cues to facilitate medication accuracy/compliance. Documentation by RN #2 and signed by SCS #2 on a case conference report dated 6/2/05 stated that the patient had missed several doses of noon medications which he was responsible for taking by himself. However, during the period from 4/22/05 to 5/28/05 there was no clinical record documentation to indicate that the patient was non-compliant with pre-poured medications. Documentation by agency nurses in the nurse visit notes on 5/29/05 and 6/8/05 stated that she reminded the patient to take the noon medications. During a joint home visit on 6/22/05, RN #2 told the surveyor that the patient did not take his noon Neurontin that was pre-poured the previous day and that he had repeatedly been forgetting to take that noon dose. When interviewed on 7/7/05 RN #2 stated, in response to surveyor inquiry, that she could not recall specific events about the patient's non-compliance with noon medications, but that she probably reported it as a something that "was occurring in general." RN #2 stated that per-diem nurses visited the patient on 5/29/05 and 6/8/05 and those nurses did not inform her that the patient missed the noon medications on those days. RN #2 stated that the patient takes Neurontin three times a day to enhance the effects of his psychotherapeutic medications. RN #2 stated that the physician was not informed until after 6/23/05 that the patient was non-compliant with the noon dose of Neurontin.
During the period from 4/22/05 to 6/22/05 there was no clinical record documentation to support that agency nurses assessed the patient's response when he was not compliant with taking Neurontin as ordered by the physician and/or that agency nurses re-evaluated that reminding the patient to take the medication did not achieve compliance and/or that the physician was informed that the patient was non-compliant with taking the Neurontin at noon each day as ordered which suggested a need to alter the plan of care.

b. Patient #8, who's date of birth was 09/15/03, had a start of care of 08/04/04 with a principal diagnosis of tracheobronchialmalacia with a tracheostomy, ventilator dependent and a gastrostomy tube. Skilled nursing was ordered 4-24 hours a day, 3-7 times a week. Included in the nursing orders was tracheostomy care and ventilator management.
On 03/17/05 an incident occurred where RN #1 failed to turn the positive end-expiratory pressure (PEEP) valve back on to ten (10) from zero (0) after a tubing change. The PEEP was off that night for approximately 7-8 hours. Between 03/18/05 and 03/22/05 the patient experienced episodes of shallow breathing, decreased heart rate and had an episode at 3am on 03/18/05 where rhonchi were heard, the heart rate and apnea alarms sounded. RN #1 woke the mother up. The patient's mother administered an albuterol treatment; the patient required suctioning which the mother performed. RN #1

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documented the mother would call the physician in the am. Interview with RN #1 on 07/01/05, she stated there were only two (2) other times during her shift since 09/04 when the patient required an albuterol treatment and suctioning; both times the mother was woken to re-assess the situation and perform the treatments. There was no clinical record documentation the physician was called concerning the rhonchi, the need for an albuterol treatment and suctioning. On 03/22/05, LPN #1 called both Primary Physician #1 and Physician #2 and informed them of the shallow breathing and decreased heart rate; the physicians were not notified at this time that the PEEP order of ten (10) was not followed and had been off for approximately 7-8 hours on 3/17/05.
RN #1 failed to set the PEEP valve to ten (10) as ordered by the physician and RN#1 failed to perform albuterol treatments and tracheostomy care as ordered by the physician. See Tags G140 and G172.

c. Patient #15 had a start of care date of 5/31/05 with diagnoses of unsteady gait, mental disorder and CHF. The plan of care dated 5/31/05 included skilled nursing 1x only, PT 1x week x 1 and 2x a week x 2 weeks. Review of the clinical record from 5/31/05 to 6/13/05 indicated that PT visited the patient 2x a week the first week and only 1x a week the second and third weeks and not 2x a week as per the plan of care.

d. Patient #18 had a start of care date of 5/16/05 with diagnoses of unsteady gait, anemia and GI bleed. The plan of care dated 5/16/05 included home health aide 3x a week x 9 weeks. Review of the clinical record from 5/16/05 to 6/10/05 indicated that the aide visited the patient 3x a week only during the week of 5/21/05 and otherwise visited the patient only 2x a week the other weeks. The aide was decreased to 2x a week as of 6/13/05.

e. Patient #21's start of care date was 4/22/05 with diagnoses including infantile cerebral palsy, mental retardation, esophageal reflux and constipation. Documentation on the certification plan of care dated 4/22/05 to 6/20/05 ordered skilled nurse once monthly to assess/instruct medication regime/compliance, safety measures and nutrition/diet; home health aide (HHA) supervision every 2 weeks, assess for skin breakdown, instruct in skin care/personal hygiene/perineal hygiene and hand washing techniques; physical therapy (PT) 1x week x 1 week; speech therapist (ST) 2x week x 2 weeks; and HHA 7 x week x 9 weeks.
Documentation by RN #6 on the nurse's summary dated 4/22/05 stated that the patient was 31 years old, known to the home health agency and lived with his parents who were willing/able caregivers. Documentation on the start of care OASIS/comprehensive assessment dated 4/22/05 stated that the patient was dependent for all activities of daily living (ADLs)/ instrumental activities of daily living (IADLs) including feeding and incontinence care for bowel and bladder. Patient #21 could not bear weight for transfers and he was nonambulatory/chairfast. Review of clinical record documentation determined that no HHA services were provided until 5/2/05 and there was no clinical record documentation to support that the nurse assessed the PCG's ability to provide care without assistance during that time and/or that she discussed when HHA services would start and/or that she offered the PCG referrals to other home health care agencies and/or that the physician was informed in a timely manner that HHA services was delayed. Documentation by RN #5 on "Reports of Interruption of

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Services" forms that were dated 5/2/05, informed the physician that no services were provided for the period from 4/23/05 to 4/29/05. Review of agency policy determined that when the start of service is delayed 24 hours beyond the agreed upon start of care date, the PCN/supervisor shall notify the patient/family including the anticipated start of service date. Additionally, the patient's physician will be notified and all communication documented into the clinical record.

Documentation on agency billing documents indicated that the patient received HHA services from 5/2-9/05, then, documentation by the HHA scheduler on a message dated 5/16/05 stated that the patient's father called to report that the HHA had not visited since 5/10/05. On 5/11/05 RN #5 documented that the HHA scheduler told her that the agency was having difficulty filling the case, but that the PCG was caring for the patient "appropriately" and he did not want to change to another agency.

Clinical record documentation determined that during the period from 5/18/05 to 6/8/05 HHA services were provided only on 5/20, 5/21 and 5/22 and not daily as ordered. Documentation by the HHA Supervisor dated 6/8/05 stated that during an unannounced HHA supervision visit the PCG told her that there had been no HHA since 5/23/05. The PCG told the HHA Supervisor that he told the aide not to come because the patient was sick and there was no need for morning personnel care. There was no clinical record documentation to indicate that that the HHA reported the patient's illness to the nurse and/or that she informed the agency that no HHA services were provided from 5/23/05 to 6/8/05. The physician was notified by SCS #3 that the patient did not receive HHA services on reports of interruption of services forms dated as follows: June 23, 2005 for 5/23 to 5/27/05 and 5/30 to 6/1/05; June 21, 2005 for 6/2 and 6/3/05; June 23, 2005 for 6/6 and 6/7/05.

When interviewed on 7/7/05 RN #3 stated that the HHA (who no longer worked for the agency) did not inform the agency that she was not providing services to the patient from 5/23/05 to 6/8/05. Rather, at the end of each week, the HHA turned in work sheets that were documented with the PCG's signature for those days. RN #3 stated that routinely, HHAs call into the agency when they arrive at the patient's home, however, RN #3 was unsure if the HHA had permission to use the patient's telephone. RN #3 stated that in such a case there is no process for the agency to monitor the HHAs arrival or the delivery of services unless the aide's absence is discovered when a supervision visit is made.

Agency nurses failed to provide services as ordered by the physician and/or failed to inform the physician in a timely manner that services were not provided as consistent with the plan of care.

f. Patient #25 had a start of care date of 6/11/04 with diagnoses including cerebral palsy, gastric tube, encephalopathy, epilepsy and convulsions. The plan of care dated 4/7/05 to 6/5/05 included private duty nursing 3-7x a wk. x 9 wks to assess CP and GI statuses, instruct and care for all equipment, assess skin, administer tube feedings and medications.

The patient's plan of care dated 4/7/05 identified that the patient was taking 28 medications.

Review of the medication administration form (MAR) for the month of May 2005, the plan of care dated 4/7/05 to 6/5/05 and the patient's medication profile identified medication discrepancies as follows:

i. Ativan 0.5mg. ¼ tablet daily G-tube was noted on the 4/7/05 plan of care but was listed on the medication profile as Ativan 0.5mg. ½ tablet .25mg daily and on the May medication administration

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record as Ativan 0.5mg ½ tablet daily. RN #3, the director of quality improvement, stated on 6/29/05 that the Ativan should have been changed to 0.25 mg ¼ tablet on the May MAR and medication profile. She stated that the correct dose was given which was "Ativan 0.25mg.1/4 tablet daily".

ii. Hydrocortisone top. 1% bid prn to the stoma site and Bacitracin oint. prn bid to stoma site following hydrocortisone was on the patient's medication profile and May MAR but was not listed on the 4/7/05 plan of care. RN #3 stated on 6/29/05 that the medications were inadvertently left off the plan of care of 4/7/05.

iii. The patient's tube feedings were listed on the 4/7/05 plan of care as Kindercal 150cc at 10AM, 200cc at 1PM and 4 PM and then continuous at 65ml/hr 8:30 PM to 7 AM. On the medication profile and MAR the tube feeding was listed as Kindercal 200ml 11:30 and 4 PM and cont. at 65ml for 11 hours overnight RN #3 stated on 6/29/05 that the 4/7/05 plan of care was incorrect and the 6/6/05 plan of care listed the correct tube feedings.

iv. Salt 0.25 tsp. daily via G- tube was listed on the May MAR and the medication profile but was listed as twice a day on the 4/7/05 plan of care. RN #3 confirmed on 6/29/05 that salt 0.25 tsp. daily is correct and that is the dose the patient had been receiving.

The nurse failed to accurately/consistently review the patient's medications to clarify medication discrepancies to ensure that Patient #25 received the correct medications at all times as ordered in the plan of care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D74(a)(1) Administration of medicines.

7. Based on clinical record review, staff interviews, home visit observations and agency policy review it was determined that for two (2) of eleven (11) patients for whom agency nurses administered and/or pre-poured medications, the nurse failed to furnish specialized nursing skill to accurately document in the clinical record all of the medications the patient was taking (Patient #s 6 and 22). The findings include:

a. Patient #6: Documentation on the recertification plan of care dated 3/7/05 to 5/5/05 ordered medications including Prolixin, Neurontin, Zyprexa, Nexium, Toprol XL, Spironolactone, Tricor and Paxil. Documentation by RN #2 on a physician's verbal order dated 5/4/05 ordered to discontinue Tricor. The surveyor observed during a joint visit on 6/22/05 that the medication administration record (MAR) dated June 1-22, 2005 included Tricor 140 mg daily and that agency nurses signed their initials daily indicating that the medication was administered. When interviewed on 6/22/05 RN #2 stated that the medication is no longer in the home and that she continued to sign (in error) that it was given. When interviewed on 6/23/05 RN #2 stated that she wrote the June 2005 MAR while visiting the patient and that when she visited Patient #6 she was distracted by the filthy environment and the patient's actions. RN #2 stated that she believed that the distractions in the patient's home interfered

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with her ability to concentrate and caused her to make the documentation errors on the MAR, but that she was sure she had not given the drug since it was discontinued.

b. Patient #22 had a start of care of 01/06/05 with a principal diagnosis of depression and secondary diagnoses including alcohol dependency, type II diabetes, hypertension, asthma and acute pancreatitis. Review of the certifications, behavioral health skilled nursing notes between 01/06/05 and 06/16/05 and the medication profile dated 03/08/05 identified medication discrepancies. There was no clinical record documentation of a medication profile or interim orders for the period 01/06/05-03/07/05 due to the loss of Patient #22's clinical record during this period.

i. On 01/06/05 RN #5 documented in the 10-day summary the patient admits to hypertension and says she takes HCTZ to control it. On 01/29/05 RN #5 documented she reviewed safe discard of needles/syringes in red container. HCTZ was not listed on the certification dated 01/06/05-03/06/05 medication list nor was there any mention of an injectable medication such as insulin.

ii. On 02/23/05, RN #5 documented the patient saw the doctor and restarted hypertension medications, Lisinopril 2.5mg qd and HCTZ 25mg 1 tab qd as the patient's blood pressure was elevated. There were duplicate certifications for the period 03/08/05-05/06/05. Both were signed on 04/08/05; one by SCS #4 and the other by RN #5. The certification signed by SCS #4 did not indicate an amount for the HCTZ; Neurontin was listed as 60mg q pm and Neurontin for 400mg q pm; no amount was listed for Lisinopril; insulin was listed as 710/30 sc q am. On 06/23/05 RN #5 wrote an interim order to the physician stating discontinue Neurontin 600mg; add Neurontin 400mg BID for the certification period 03/08/05-05/06/05.

The certification signed by RN #5 listed HCTZ 25mg qam; Neurontin 600mg q pm and Neurontin 400mg q pm; no amount was listed for Lisinopril; insulin was listed as 70/30 sc q am.

On 02/28/05 and 06/16/05 RN #5 documented Prevacid 30mg qd, needs refill. Prevacid was not listed on any of the certifications nor was a diagnosis listed indicating the need for Prevacid; interview with RN #5 on 07/14/05, she stated she recollects the patient had GERD. Asthma was listed as an active diagnosis on the 01/16/05-03/06/05 certification, however there were no asthma medications listed. On the two (2) certifications dated 03/08/05-05/06/05 and on the medication profile dated 03/08/05, Advair inhaler 25/50 1 puff PRN was listed.

On 03/08/05, RN #5 documented in the behavioral health nursing note the patient was started on an antibiotic and Claritan-D. These medications were not listed on the certifications dated 03/08/05-05/06/05 or on the medication profile dated 03/08/05.

The agency failed to ensure that all clinical record documents were accurate pertaining to medications and to ensure that medication discrepancies did not occur. Due to the medication discrepancies and the loss of the clinical record, it is either unknown or unable to be confirmed that the correct medications were pre-poured for Patient #22 for the period from 1/6/05 to 6/16/05.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D75(a)(1) Clinical record system.

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8. Based on clinical record review, staff interview and policy review, it was determined that the agency failed to ensure that the clinical record of Patient #22 was kept secure at all times as evidenced by the following:

a. Patient #22 had start of care dates of 01/06/05 and 03/08/05. The clinical record from 01/06/06 thru 03/07/05 was discovered missing around March 29, 2005.
i. Review of the agency policy and procedure concerning physical security in the protection of protected health information stated clinical records are protected against loss and unauthorized use and disclosure by being kept in attended areas during business hours and in a locked room after business hours; permanent records are not removed from the agency office except by court order, for storage, or in the event of potential defacement/damage from a weather or civil emergency; the medical records room staff will verify that the individual requesting the record has an access code which allows access to the requested information.
ii. Interview with SCS #4 on 06/28/05, she stated the agency does not know where this record is nor do they know how it disappeared. SCS #4 stated she takes full responsibility for the loss of Patient #22's clinical record.
The agency failed to ensure clinical records are kept secure at all times and adequately protect them against loss.